



1730 M Street, NW, Suite 502
Washington, DC 20036

phone » (202) 659-9440
fax » (202) 659-9422
web » www.ahima.org

June 22, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1406-P**
PO Box 8011
Baltimore, Maryland 21244-1850

Dear Ms. Frizzera:

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 (IP-PPS) and fiscal year 2010 Rates, as published in the May 22, 2009 *Federal Register* (CMS-1406-P).

AHIMA is a professional association representing more than 54,000 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. As part of our effort to promote consistent coding practices, AHIMA is 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 *International Classification of Diseases Ninth Revision, Clinical Modification* (ICD-9-CM). AHIMA members are also deeply involved with the development and analysis of healthcare secondary reporting data including that 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-D – Proposed FY 2010 MS-DRG Documentation and Coding Adjustment, Including the Applicability to the Hospital-Specific Rates and the Puerto Rico-Specific Standardized Amount_(74FR24092)

AHIMA opposes CMS' proposal for a 1.9 percent payment cut to eliminate the suggested effect of changes in coding or classification that do not reflect real changes in case mix.

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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 and does not advocate the practice of only coding those diagnoses and procedures necessary for correct DRG assignment.

CMS has encouraged hospitals to improve their coding specificity. For example, in the FY 2008 IP-PPS final rule, CMS stated the following, in reference to the coding of heart failure:

"We believe it is very important for hospitals and physicians to use the most specific codes that describe the incidence of heart failure in their patients. In order to accurately and completely evaluate healthcare outcomes for the treatment of heart failure, detailed and accurate information is needed on patients with this condition. Physicians and hospitals will undermine efforts to obtain more information on patients with this disease when they a nonspecific code when there is a more detailed code to describe their patient. We highly encourage physicians and hospitals to work together to use the most specific codes that describe their patients' conditions. Such an effort will not only result in more accurate payment by Medicare but will provide better information on the incidence of this disease in the Medicare patient population."

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.

The proposed documentation and coding adjustment goes against CMS' efforts to encourage hospitals to improve their coding specificity and is inconsistent with national goals to improve quality of care. In the ICD-10 final rule, CMS stated "With better and more accurate data, patient care can only be improved."

Also, we believe that CMS' conclusions regarding the impact of coding and documentation practices may be inaccurate, based on information we've received from our members concerning data analyses by other organizations. **Due to our belief that providers should be rewarded, not penalized, for improved coding accuracy and specificity, and the fact that we are aware analyses by other organizations disagree with CMS' finding (and have shown real increases in patient severity), we urge CMS to significantly mitigate its proposed documentation and coding payment cut.**

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II-F-5 – Preventable Hospital-Acquired Conditions (HACs), Including Infections: Public Input Regarding Selected and Potential Candidate HACs (74FR24106)

AHIMA commends CMS for not moving forward with changing the HAC list without conducting some initial program analysis and evaluation of the data. Conducting this assessment and gaining a better understanding of the program that was implemented for FY 2009 provides for a thoughtful and informed decision-making process when determining next steps.

II-G-2 – MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Infected Hip and Knee Replacements (74FR24107)

While we support the re-assignment of ICD-9-CM procedure codes 80.05 and 80.06 to MS-DRGs 463, 464, and 465, we recommend that the titles of these MS-DRGs be revised to appropriately reflect the inclusion of these procedures.

II-G-3e – Proposed Creation of New Edit Titled “Wrong Surgeries” (74FR24110)

The proposal to create a new edit to identify cases in which wrong surgeries occurred that would be triggered when one of three E codes is reported implies a change in CMS’ longstanding policy that they don’t require the reporting of E codes. However, a change in this policy is not explicitly stated. **We ask CMS to provide clarification regarding changes to their policy on E code reporting.**

The rule notes that E codes E876.5 through E876.7 will trigger the “Wrong Surgery” edit when they are reported in either the principal or secondary diagnosis position. Per the *ICD-9-CM Official Guidelines for Coding and Reporting*, E codes should never be reported as the principal diagnosis. Since there is an existing MCE edit “E code as principal diagnosis,” which would require the hospital to correct and resubmit the claim, it is not clear why the proposed new edit for “wrong surgery” should be triggered when an E code is reported as the principal diagnosis. This might encourage incorrect coding. AHIMA recommends that if one of the E codes for incorrect surgeries is reported as the principal diagnosis, the claim should be returned to the hospital so that it can be resubmitted with the correct codes in the correct sequence. The “wrong surgery” edit should only be triggered when the E codes are reported in the correct position on the claim.

E codes may be reported in either the unique E code field or in a secondary diagnosis position. Since the rule indicates the proposed edit for “wrong surgeries” will be triggered when one of the designated E codes is reported in a secondary diagnosis position, it is not clear if the edit would also be triggered if one of the E codes was reported in the E code position. The edit should be triggered if the E code is reported in either the E code position or a secondary diagnosis position.

CMS states in the rule that any claim with this edit will be denied and returned to the provider. When a claim is returned to the provider, it generally means it should be corrected and resubmitted. However, in this case, it is a correctly submitted claim. Also, will the claim be completely denied, or is there a way for the hospital to be reimbursed for services unrelated to the incorrect surgery?

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AHIMA recommends, as we have in previous comment letters, that CMS begin processing all of the reported diagnosis and procedure codes, even before ICD-10-CM and ICD-10-PCS are implemented. With mounting requirements for more detailed coded data, it is increasingly likely that codes for significant conditions or procedures will be reported below those that are processed by Medicare. The proposed new edit for “wrong surgeries” is a good example. External cause codes (E codes) are often reported after the codes for acute conditions. This might mean that an E code indicating an incorrect surgery could be sequenced below the nine diagnoses processed by Medicare. Currently, there are no official coding guidelines or CMS directives mandating the sequencing of secondary diagnoses.

V-A-1c(1) – Quality Measures (74FR24167)

AHIMA supports efforts to discontinue data collection and reporting requirements for measures that have evidence supporting differing approaches and are no longer consistent with current clinical guidelines, especially in situations where the burden associated with data collection and reporting outweighs the benefit of public reporting.

V-A-1c(2) – Maintenance of Technical Specifications for Quality Measures (74FR24167)

AHIMA agrees that timely updates to quality measures are necessary for maintaining comparable and credible measurement results. We support CMS’ plans to provide notifications through the QualityNet and specification manual venues.

V-A-3b(4) – Proposed New Structural Measures (74FR24170)

AHIMA commends CMS for the promotion and use of registries for data collection as well as consideration for future use of data collection to reduce the burden of manual data collection. AHIMA is concerned there may be hospitals who do not currently participate in registries and may be required to participate in these proprietary registries in the future. We request clarity on what alternatives hospitals will have to provide information for future considerations should they not have the resources to participate in registry-based data collection initiatives.

V-A-4 – Possible New Quality Measures for the FY 2012 Payment Determination and Subsequent Years (74FR24172)

CMS is proposing a significant increase in the number of quality measures that will be required for reporting FY 2012. As there are many other critical initiatives going on at this time – HIT adoption for incentive payments and the final year before ICD-10-CM and ICD-10-PCS implementation – we are concerned that the number of measures proposed may serve as a disincentive toward the adoption of EHRs when this is a particularly critical time as the ARRA incentive payments begin in 2011. AHIMA recommends CMS gives consideration to the number and burden of measures being proposed particularly as they are not EHR-based or registry based measures.

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Additionally, it is unclear whether the measures CMS is proposing for FY 2012 are currently endorsed by NQF or are undergoing the endorsement process by NQF; and which measures would require manual data abstraction versus claims-based analysis. It has been CMS' practice and commitment to adopt those measures that are endorsed by NQF or under review, and that leverage alternative sources of data to minimize data collection burden to hospitals. AHIMA recommends that CMS provide clarity on the status of the proposed measures regarding NQF endorsement and data abstraction burden.

V-A-7 – Data Accuracy and Completeness Acknowledgement Requirements for the FY 2011 Payment Determination and Subsequent Years (74FR24180)

AHIMA commends CMS for proposing to implement an attestation program that allows hospitals to submit acknowledgement the completeness and accuracy of their data through an electronic method.

V-A-11b – EHR Testing of Quality Measures Submission (74FR24182)

Uniform data content standards are crucial in the effort to reduce burdens for hospitals. These standards will facilitate a process for automated data transmission, and electronic health record (EHR) vendors will be more apt to integrate measurement reporting capabilities into EHR products if measure specifications are standardized across the industry. This will streamline hospital data submission procedures and enable providers to view real-time measurement results to initiate their own improvement interventions in a more timely and efficient manner.

AHIMA commends and supports CMS' acknowledgement and support of the development and adoption of data content and information technology standards that will support automated data collection and reporting of clinical data from EHR systems. Recognizing the efforts conducted by CCHIT, the NHIN and HITSP is imperative to achieving meaningful use of HIT as well as the overall adoption of technology in the healthcare setting.

Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare Hospital Inpatient PPS program for FY 2010.

AHIMA commends CMS for adoption of the ICD-10-CM and ICD-10-PCS code sets. This is a very important step toward producing the precise and accurate data needed to support 21st century healthcare initiatives and the national goals of improved healthcare quality, safety, and efficiency.

AHIMA continues to recommend that CMS process all reported diagnoses and procedures.

Accurate conclusions about patients' severity of illness and quality of care cannot be reached without a complete picture of their clinical conditions and services provided.

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AHIMA stands ready to work 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,

A handwritten signature in black ink that reads "Sue Bowman". The signature is written in a cursive, flowing style.

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

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