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June 30, 2009

Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1410–P
PO Box 8016
Baltimore, Maryland 21244-8016

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 Skilled Nursing Facilities Inpatient Prospective Payment Systems (SBF-PPS) as published in the May 12, 2009 *Federal Register* [74FR22208].

AHIMA is a professional association representing more than 54,000 health information management (HIM) professionals who work throughout the healthcare industry. Because of our concern for clinical documentation and data integrity, AHIMA and its members have become deeply engaged in the development and maintenance efforts of terminology and classification standards as well as administrative and clinical transaction standards.

Our classification and standards efforts have afforded us the opportunity to collaborate with federal agencies, especially the Department of Health and Human Services (HHS), and experience the movement toward the adoption and use of uniform and consistent data standards. Since 2007, our involvement has also included the application of content and exchange standards for the Minimum Data Set, Versions 2.0 and 3.0 (MDS 3.0) through the AHIMA Foundation contract with the Assistant Secretary for Planning and Evaluation (ASPE). Because of our active involvement and dedication to the use of standards and data integrity we make the following comments with regard to your proposals on page 74FR22241 section IV:

1. Benefits of standards-based MDS transmission

The proposed rule currently calls for custom transmission of MDS versus the use of HHS accepted standards. By requiring custom transmission of MDS, vendors and providers will be forced to slow their participation in national health information exchange initiatives by diverting resources and focus and develop programs for CMS compliance first, then focusing their efforts on health information exchange.

By incorporating standards based formats for MDS transmission, providers and vendors will experience an overall lower cost of implementation. Continuing to require custom-based XML for transmission of data, vendors and providers must develop two different programs in tandem for the same purpose. This approach is inconsistent with the overall policies and programs that HHS and the Office of the National Coordinator for Health Information Technology (ONC). To improve cost savings, increase participation in health information exchanges and realize other benefits of a standards based approach, AHIMA recommends CMS reevaluate the need for using XML and consider using a standards-based approach for data transmission including planning for content standards. We specifically recommend the following:

2. HL7 CDA Standard for MDS

CMS anticipates using XML standards for the MDS 3.0 transition; however, the HL7 CDA (Clinical Document Architecture) is a formal implementation of XML that is used to specify aspects of clinical documents for exchange. The CCD (Continuity of Care Document) standard is a more specific implementation of CDA (and therefore of XML) used to communicate health information summaries and are currently the national and certified standard for communicating such summaries. Specific guidance for supporting electronic transmission of patient assessment questionnaires such as MDS, OASIS as well as non-regulatory assessments is now available from the HL7 Patient Assessment Questionnaire framework.

Technically, there is no difference between supporting a CDA based transmission or XML based information. Because CDA is fundamentally XML it therefore means that CMS will experience minimal interruption in the development of deliverables which would allow CMS to maintain existing project schedules. Additionally, CMS will experience lower testing and validation costs as testing platforms currently exist for CDA documents. Rather than developing a custom based data transmission process, AHIMA strongly recommends CMS to reevaluate the benefits and usage of CDA for the MDS 3.0 including the applicable content standards (LOINC and SNOMED-CT). We are pleased to work with CMS on further consideration and implementation of SNOMED, recognizing that the industry is moving toward SNOMED-based EHRs.

3. File Resource Requirements

The CDA implementation may have significantly larger files than the custom XML programmed by CMS. However, consideration must be given toward the impact on storage and transmission capacities that will remain reasonable compared with other document types (i.e. claims attachments). We estimate that total storage and transmission costs will be minimal. Moreover, a recent ASPE contract with the AHIMA Foundation developed a transformation tool that would allow standards-based MDS transmission to be directly converted to the internal format that CMS has been developing. This process would eliminate the need for CMS to redevelop any internal processes for supporting MDS 3.0 data. AHIMA recommends that CMS communicate the availability of the transform tool to the nursing home industry if it cannot support the CDA for transmission. AHIMA also recommends that CMS

commission a pilot project to move MDS 3.0 transmission to a CDA-based transmission format in the future.

4. ICD-10-CM

The compliance date for ICD-10-CM is October 1, 2013, and we encourage CMS' ICD-10 transition team to plan for the impact on the MDS 3.0 as they move forward in preparing for the migration to the ICD-10 code sets. CD-10-CM codes have a maximum length of 7 characters, not including the decimal point. As currently structured, the MDS 3.0 form would need 8 fields to accommodate the ICD-10-CM code including the decimal (the October 2008 version only has 7 fields). However, AHIMA recommends that CMS consider adopting the diagnosis code format used in the OASIS data set.

In the draft MDS 3.0 document, the instructions indicate that the decimal must be manually entered in the appropriate box. This approach introduces the possibility of manually entering the decimal in the wrong box. On the OASIS form, the decimal point is shown after the third character in the diagnosis code format and does not need to be manually entered. Since the decimal always appears after the third character in both ICD-9-CM and ICD-10-CM diagnosis codes, displaying the decimal point eliminates unnecessary manual data entry and associated errors. We recommend that code formats be consistent across various assessment instruments. In addition to the MDS 3.0 form, AHIMA would like to offer our assistance with identifying applicable ICD-10-CM codes for Section I in the MDS 3.0 manual and mapping ICD-9-CM codes to ICD-10-CM codes where applicable for quality indicators and measures.

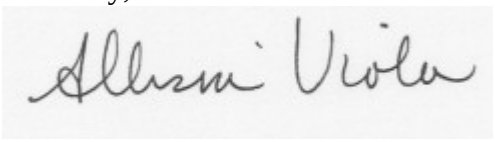
As part of the ASPE contract with the AHIMA Foundation, a preliminary mapping to ICD-10-CM for section Ia items has been completed. In addition, AHIMA has been engaged with the ICD-10-CM and ICD-10-PCS migration efforts for many years; more recently the AHIMA Foundation completed a project with CMS to conduct an impact assessment on the implementation of ICD-10-CM and ICD-10-PCS, along with other initiatives.

AHIMA has consistently supported and agreed with HHS' move in the direction of adopting uniform standards across the nation. Currently, there are numerous efforts by HHS and the healthcare industry (including skilled nursing facilities) associated with the recent passage of the American Recovery and Reinvestment Act (ARRA) to see the adoption of uniform electronic health records (EHRs) and uniform health information exchange (HIE). The recommendations by CMS outlined in the May 12, 2009, notice are inconsistent with initiatives supported by HHS and ONC. We strongly urge CMS to adopt the HHS accepted national standards that will support a minimum data set that will be in concert with these other efforts and not go forward with the adoption as proposed.

AHIMA stands ready to work with CMS, HHS, and ONC to ensure a smooth adoption and implementation of a MDS as we have suggested. We welcome any questions or concerns you might have with our comments and recommendations above, please contact either Sue Bowman, RHIA,

CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or me at (202) 659-9440 or allison.viola@ahima.org.

Sincerely,



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