



June 7, 2007

Leslie Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1533-P**
PO Box 8011
Baltimore, Maryland 21244-1850

Dear Ms. Norwalk:

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 2008 Rates, as published in the May 3, 2007 *Federal Register* (CMS-1533-P).

AHIMA is a professional association representing more than 51,000 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.

CMS is proposing adoption of a new severity-adjusted DRG system, MS-DRGs, for FY 2008. However, **AHIMA recommends that implementation of a severity-adjusted DRG system be delayed until FY 2009, when the Rand report is final, the most appropriate severity-adjusted DRG system can be selected, and ample time exists for implementation.**

In previous years, AHIMA's recognition of the industry's need for consistency in medical coding, improved data integrity, and more precise and contemporary data reflecting 21st century medicine has led AHIMA to advocate for adoption and coordinated implementation of ICD-10-CM and ICD-10-PCS in our comments on the IP-PPS. It is unfortunate that, as new initiatives that rely heavily on coded data gain momentum (such as present on admission reporting, pay-for-performance, and DRG refinements to better recognize severity of illness), ICD-10-CM and ICD-10-PCS still have not been implemented as replacements for ICD-9-CM.

If the obsolete ICD-9-CM coding system had been replaced earlier, claims data that would significantly add to the knowledge needed to measure severity, quality, and other factors under consideration would now be available. The proposed MS-DRG system and other proposals in this year's proposed rule are excellent examples of how ICD-10-CM and ICD-10-PCS could improve the ability to refine reimbursement systems in order to better reflect severity of illness. We will point out these examples throughout our comments and we urge CMS and the Department of Health and Human Services (HHS) to take immediate action to secure the adoption and implementation of these two classification systems, and supporting transaction standards as early as possible.

Our detailed comments and rationale are below.

II-D: DRG Reform and Proposed MS-DRGs (72FR24691)

II-D-1 – Evaluation of Alternative Severity-Adjusted DRG Systems (72FR24691)

AHIMA agrees that RAND should evaluate the proposed MS-DRGs using the same criteria it applies to the other DRG systems; however, we are concerned that CMS is proposing adoption of the MS-DRG system without completion of this evaluation. Since RAND is engaged to evaluate alternative DRG systems that may better recognize severity than the current CMS DRGs, it is premature to select and implement a severity-adjusted DRG system before completion of the evaluation and without having your decisions based on this analysis.

The MS-DRG system was not included in the draft interim report, and how it measures up against the other systems being evaluated is still unknown. The potential that implementation of MS-DRGs for fiscal year 2008 could be a one-year stopgap measure, should CMS choose to select an alternative system for implementation next year (as a result of RAND's final report of their evaluation of alternative DRG systems), is problematic and costly. Implementing a new DRG system is a major change that involves significant investment in education and systems changes. Also, comparability of DRG data will be impacted each time a new system is implemented.

AHIMA recommends that CMS delay implementation of a severity-adjusted DRG system until RAND's final report is available and a thoughtful decision, based on RAND's evaluation, can be made.

II-D-2 – Development of Proposed Medicare Severity DRGs (72FR24697)

AHIMA opposes the re-use of the current CMS DRG numbers in the MS-DRG system. Although we acknowledge the advantages of maintaining the current three-digit numerical scheme, we believe the

use of the same DRG numbers in both the current CMS DRG and MS-DRG systems will create confusion when analyzing longitudinal data, given the same DRG number will have a different meaning in the two systems. Delaying implementation of a severity-adjusted DRG system until FY 2009 would allow additional time for making more extensive systems modifications, such as adopting an alphanumeric or four-digit numerical structure for the new DRG system.

We commend CMS for undertaking a long-overdue comprehensive review and revision of the CC list. However, **AHIMA believes more industry input is needed regarding the revised CC and the CC and MCC designation in the MS-DRG system.** The brevity of the public comment period in combination with insufficient detail associated with the process and rationale for categorization of diagnoses as MCCs, CCs, and non-CCs made it very difficult to conduct a thorough analysis of all of the codes on the MCC and CC lists. However, we have identified a few concerns regarding the CC/MCC lists:

- **AHIMA disagrees with the decision to designate code 428.0, Congestive heart failure, unspecified, a non-CC.** The proposed rule incorrectly characterized the diastolic and systolic heart failure codes as congestive heart failure codes. Per the Fourth Quarter 2002 issue of *Coding Clinic for ICD-9-CM*, congestive heart failure is not an inherent component of the codes in category 428 for systolic and diastolic heart failure. According to *Coding Clinic*, code 428.0 should be assigned as an additional code when the patient has systolic or diastolic congestive heart failure. Also, code 428.0 may appropriately be assigned by itself when congestive heart failure is documented, but there is no documentation of systolic or diastolic heart failure. In ICD-9-CM, there is no distinction between an acute exacerbation of congestive heart failure and chronic congestive heart failure. Code 428.0 is assigned for both. Also, codes 402.11 (benign hypertensive heart disease with congestive heart failure) and 402.91 (unspecified hypertensive heart disease with congestive heart failure) are on the CC list. We believe **code 428.0 should be included on the revised CC list as well.**
- **There are unexplained inconsistencies within the designation of non-CC, CC, and MCC.** For example:
 - While congestive heart failure (code 428.0) and benign and unspecified essential hypertension (401.1 and 401.9) individually have been designated as a non-CC, combination codes 402.11 (benign hypertensive heart disease with congestive heart failure) and 402.91 (unspecified hypertensive heart disease with congestive heart failure) are listed as CCs.
 - Other protein-calorie malnutrition and unspecified protein-calorie malnutrition (codes 263.8 and 263.9) are on the CC list, but mild and moderate malnutrition (codes 263.1 and 263.0) are not.
- Based on input from our members regarding the resources required to treat these conditions, we believe **the following codes should be retained on the CC list:**
 - 285.1, Acute posthemorrhagic anemia
 - 413.9, Other and unspecified angina pectoris
 - 427.31, Atrial fibrillation
 - 492.8, Other emphysema
 - 496, Chronic airway obstruction NEC
 - 599.7, Hematuria
 - 780.39, Other convulsions
 - 786.03, Apnea

- 799.02, Hypoxemia
- In some cases, the current ICD-9-CM classification system does not adequately distinguish between acute and chronic forms of a condition. In the MS-DRG system, this distinction appears to be critical in predicting resources utilized at the patient level. **AHIMA recommends that CMS work with the National Center for Health Statistics (NCHS) to make ICD-9-CM code modifications to improve this acute and chronic distinction.** Additionally, CMS and HHS should take immediate steps for the adoption of ICD-10-CM, as this system is much better than ICD-9-CM at distinguishing clinical severity, which is a key aspect of any severity-adjusted DRG system. Continued use of ICD-9-CM severely limits the ability of a severity-adjusted DRG system to recognize severity of illness.

II-D-4 – Conclusion (72FR24706)

AHIMA commends CMS' responsiveness to last year's PPS public comments in the development of a severity-adjusted DRG system. Clearly, the MS-DRG system does a better job than last year's proposed CS-DRGs of reflecting medical technology and other improvements, made over the years, in the current CMS DRG system. However, **AHIMA believes implementation of a severity-adjusted DRG system should be delayed until FY 2009, when the Rand report is final, the most appropriate severity-adjusted DRG system can be selected, and ample time exists for implementation.**

AHIMA believes there is insufficient implementation time – essentially 61 calendar days – between the publication of the final rule at the beginning of August and proposed implementation of MS-DRGs on October 1. Although the MS-DRG system is based on the current CMS DRG system:

- The structure, grouping logic, and CC list are quite different.
- Systems changes will need to be made, such as creating a new data element for the MS-DRG.
- Systems edits or analytic reports based on DRGs will need to be modified.
- Encoding and grouping software will need to be modified.
- Hospital staff and physicians must be educated.

It is not clear if software vendors will be ready in time. Also, a grouper and definitions manual are not yet available, and without these resources, it is not possible to fully understand, evaluate, or analyze the specifics related to the assignment of an MS-DRG at a case or even an aggregate DRG level.

Use of ICD-10-CM and ICD-10-PCS would provide a much better foundation for a severity-adjusted DRG system than ICD-9-CM. The value of MS-DRGs or any other severity-adjusted DRG system that relies on claims data will be limited by the continued use of an obsolete, non-specific classification system. ICD-10-CM and ICD-10-PCS would provide greater clinical detail, and up-to-date clinical information for capturing information on disease severity, including complications, co-morbidities and risk factors, as well as more detailed information on the use of medical technology and its impact on resource utilization and outcomes. The longer adoptions of contemporary classifications are delayed, the more CMS must develop alternatives that become costly to administer and for providers costly to continually implement.

II-D-5 – Impact of the Proposed MS-DRGs (72FR24707)

AHIMA opposes CMS' proposal to reduce the IPPS standardized payment amounts by 2.4 percent each year for FY 2008 and FY 2009 to eliminate the suggested effect of changes in coding or classification that do not reflect real changes in case mix. This proposed behavioral offset has no basis in actual data or research pertaining to inpatient hospital coding practices.

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 enough diagnoses and procedures for correct DRG assignment.

We acknowledge that at the time the prospective payment system was first introduced in the early 1980s, coding accuracy was not at the level it should have been. However, much has changed since then. Increased attention to the quality of coding and documentation as a result of the role coding plays in DRG assignment has led to much-improved coding practices. And hospitals began to realize that in order for CMS to make DRG modifications that would recognize the resource-intensiveness of a diagnosis or procedure, that diagnosis or procedure must be included in the reported codes so that it would be included in CMS' data.

It is unknown how many hospitals, if any, code only the diagnoses and procedures that affect reimbursement rather than coding all reportable diagnoses and procedures. Further, since CMS only processes nine diagnosis and six procedure codes, CMS has no way of knowing how many codes that currently do not affect the CMS DRG assignment, but would affect the MS-DRG, are being reported beyond the ninth diagnosis and sixth procedure codes.

The Maryland experience with APR-DRG implementation is used as a basis for projecting behavioral changes in the wider national hospital population. AHIMA believes the Maryland experience is not an appropriate basis for projecting changes in coding as a result of MS-DRG implementation. Prior to APR-DRG implementation, Maryland hospitals were not paid using a DRG system. DRG data was collected for statistical purposes, but DRGs were not used for reimbursement. Unlike the rest of US hospitals, Maryland hospitals did not have prior experience coding under a DRG system, and therefore, we do not believe their experience with APR-DRG implementation is at all similar to the rest of the country's experience with MS-DRG implementation. Coding practices under APR-DRGs are not necessarily comparable to that under MS-DRGs. For example, since APR-DRGs were not designed for reimbursement purposes, we have found that the system logic is not always consistent with nationally recognized coding rules and guidelines, resulting in possible changes in coding practices that do not necessarily represent improved coding. Since MS-DRGs are based on a DRG system designed for reimbursement, we are not aware of similar conflicts with nationally recognized coding practices in the MS-DRG system.

Although RAND Corporation acknowledged in its interim report on alternative DRG systems that changes in coding patterns or behavior could improve payments with each severity adjusted DRG system,

the interim report also noted that coding behaviors are expected to vary under alternative systems. RAND compared the potential for coding improvements among the various systems they evaluated, based on the logic of each DRG system. However, an evaluation of MS-DRGs is not included in RAND's interim report and is not expected until the final report. RAND noted, that without having the opportunity to observe actual changes in coding behavior when a DRG system is used for payment, it was not able to empirically assess the relative risk the alternative severity-adjusted systems pose for case mix increases attributable to coding improvement.

AHIMA does not believe any payment adjustment to account for case mix increases, which are attributable to coding improvements, should be made until CMS has conducted appropriate research to determine the extent to which this would become an issue under the proposed MS-DRG system. While the design of the MS-DRG system may encourage an increased level of coding specificity, it is unknown what effect, if any, this might have on the case mix index. As noted earlier, we believe most hospitals are already coding all diagnoses and procedures in accordance with official coding rules and guidelines.

AHIMA continues to recommend that CMS process all reported diagnoses and procedures. CMS' failure to process more than nine diagnoses and six procedures is one of the most common complaints from our members. A complete picture of the patient's diagnoses and procedures is needed to fully represent the severity of illness and accurately calculate the DRG in any severity-adjusted DRG system. The development of the MS-DRG system was based on incomplete data due to Medicare's failure to process more than nine diagnoses and six procedures. The severity of illness of hospital inpatients has increased over the last decade, due to shifts in the provision of care from the inpatient to outpatient setting. This has led to an increase in the number of comorbidities per hospital admission. Demands for greater coding specificity have also led to an increase in the number of reported diagnosis and procedure codes. Given this situation, **AHIMA recommends that hospitals report all codes that are reportable according to the ICD-9-CM Official Guidelines for Coding and Reporting and that CMS accept and use all submitted codes in the DRG calculation.**

If there is variability in the completeness of hospital coding practices, AHIMA agrees with RAND that the amount of coding improvement is likely to vary across hospitals, depending on how strong their current coding practices are and the resources they are able to devote to improving them. Therefore, we also agree with RAND that CMS' practice of making an across-the-board adjustment to PPS payments to address case mix increases attributable to coding improvements raises an equity issue that CMS needs to consider.

II-F: Hospital-Acquired Conditions, Including Infections (72FR24717)

Since the Deficit Reduction Act only requires the selection of two hospital-acquired conditions, **AHIMA recommends that for fiscal year 2008, CMS adopt only two conditions that would not result in the higher-weighted DRG assignment when they are not present on admission.** Since this is a new concept for both hospitals and CMS, we believe it would be best to start out slow in order to ensure accurate data collection and to ensure that payment reduction is limited to conditions that are the most likely to be preventable.

Again, we urge CMS to adopt ICD-10-CM and ICD-10-PCS, as these improved classification systems would greatly enhance the quality of present on admission data and the identification of hospital-acquired conditions.

Specific comments on proposed hospital-acquired conditions:

- Catheter-associated urinary tract infection: Although identification of this condition is complicated by the need to assign two codes to fully capture the condition, there are ICD-9-CM codes that clearly describe this condition. Our members indicate that documentation will be an issue, as the physician documentation must link the urinary tract infection with the catheter in order to assign code 996.64, Infection and inflammatory reaction due to indwelling urinary catheter.
- Pressure ulcers: This is an excellent example of why ICD-10-CM would be a much better system for reporting hospital-acquired conditions than ICD-9-CM. ICD-10-CM distinguishes the various stages of pressure ulcers, whereas ICD-9-CM does not. If pressure ulcer is selected as one of the hospital-acquired conditions, CMS will need to provide both a clinical definition of a pressure ulcer and instructions regarding the reporting of a pressure ulcer that progresses during the hospital stay (for example, clarification as to the reporting of an early stage, or pre-ulcer stage, at the time of admission that progresses to a full-blown pressure ulcer, or a more severe stage, during the hospitalization is needed).
- Serious Preventable Event–Object Left in During Surgery: There is a specific code to identify this circumstance. However, we believe several issues will need to be clarified prior to implementing this circumstance as one of the hospital-acquired infections. Clarification is needed as to whether code 998.4 should be assigned when a foreign body is discovered and removed prior to the patient leaving the operating room. Situations whereby the original surgery was performed during a previous encounter or at a different hospital also need to be clarified. In other words, code 998.4 may be reported for a different encounter or by a different hospital than the one where the original surgery was performed.
- Serious Preventable Event–Air Embolism: There is a specific code to identify this condition.
- Serious Preventable Event–Blood Incompatibility: There is a specific code to identify this condition.
- Staphylococcus Aureus Bloodstream Infection/Septicemia: **We oppose adopting septicemia as one of the hospital-acquired conditions.** Although there are specific codes to identify this condition, it is very difficult to determine whether it truly developed after admission or is a progression of an infection the patient had at the time of admission. We do not believe that creating an exclusion list would entirely resolve this problem. For example, the causal organism for an infection present at the time of admission, such as pneumonia, might not be determined, but that doesn't mean it is not related to the septicemia that develops later. In this case, the code for pneumonia, organism unspecified, would be assigned instead of the code for Staphylococcus aureus pneumonia.
- Ventilator Associated Pneumonia: We agree with CMS that ventilator-associated pneumonia should not be selected as one of the hospital-acquired conditions at this time because there is no unique ICD-9-CM code and there is no clear definition as to what constitutes ventilator-associated pneumonia.
- Vascular Catheter-Associated Infections: We agree with CMS that vascular catheter-associated infections should not be selected as one of the hospital-acquired conditions at this time because there is no unique ICD-9-CM code. CMS noted in the proposed rule that the associated specific infection codes would have to be identified so that they would not count as a CC. In the case of sepsis due to a vascular catheter, the code for sepsis (995.91) or severe sepsis (995.92) would be

assigned in addition to the codes for vascular catheter-associated infections and the specific infection, and these codes are also CCs.

- Clostridium Difficile-Associated Disease: While there is a specific ICD-9-CM code for this condition, we agree with CMS that it should not be selected as one of the hospital-acquired conditions because of the lack of prevention guidelines.
- Methicillin-Resistant Staphylococcus Aureus (MRSA): We agree that it would be difficult to clearly identify MRSA infections. Using a combination of code V09.0 and specific codes for infections due to Staphylococcus aureus would be problematic because not all infection codes identify the responsible organism (for example, code 998.59, other postoperative infection).
- Surgical Site Infections: As CMS indicated, there is currently no ICD-9-CM code that uniquely identifies surgical site infections.
- Serious Preventable Event-Surgery on Wrong Body Part, Patient, or Wrong Surgery: We agree with CMS' decision not to select this circumstance as one of the hospital-acquired conditions for all of the reasons stated in the proposed rule.
- Falls: Even if a unique code existed to identify falls occurring in the hospital, a fall does not necessarily mean any injury has occurred. To include falls as one of the hospital-acquired conditions, CMS would need to link the occurrence of a fall with an injury.

II-G: Proposed Changes to Specific DRG Classifications (72FR24726)

Unless otherwise noted, AHIMA supports CMS' proposed changes to specific DRG classifications.

II-G-4b – Spinal Fusions (72FR24731)

We support the reassignment of spinal fusion cases with a principal diagnosis of tuberculosis or osteomyelitis to DRGs that better account for resource utilization. However, to classify patients with these diagnoses to the proposed MS-DRGs 456, 457, and 458 would require a modification of the DRG titles. MS-DRGs 456, 457, and 458 are defined as patients with diagnoses of spinal curvature and malignancies, whereas tuberculosis and osteomyelitis are infectious processes and do not fit into this description.

IV-A: Reporting of Hospital Quality Data for Annual Hospital Payment Update

IV-A-1 – Background (72FR24802)

As stated in our previous comment letters, AHIMA remains concerned that even though there is an active program under way to develop standard measurements for quality, the lack of detailed diagnoses and procedure data, that could be available with the use of ICD-10-CM and ICD-10-PCS, will make the information gathered incomplete and inconsistent when it comes to using it for the measurement of quality and other factors.

As CMS continues to develop and require implementation of quality measures, the additional measures increase the burden on hospitals to report on the defined measures. Although it is imperative to measure the quality of treatment and patient care, the cost of increasing burdens of reporting may cause programs to collapse under the weight of trying to meet CMS' requirements. Additionally, the cost of reporting on the required measures will eventually outpace the bonus payments whether voluntary reporting or not.

AHIMA recommends providing additional information regarding the criteria and process by which the Secretary will retire and/or replace quality measures. Providing information such as timelines and the decision process will allow the healthcare providers and vendors to prepare and plan resources, should the replacement measures be implemented.

AHIMA applauds CMS' efforts to reflect consensus in the healthcare quality sector and looks forward to reviewing the measures incorporated into the future quality efforts. AHIMA recommends that CMS identify what organizations will be selected to set forth the recommended measures for acceptance. By identifying the organizations, it will make the process more transparent and allow the industry to understand and review the measure development and selection process.

IV-A-2 – FY 2008 Quality Measures (72FR24804)

The Value-Based Purchasing (VBP) program that CMS is implementing beginning FY 2009 identifies the measure for percutaneous coronary intervention for acute myocardial infarction as being within 90 minutes of hospital arrival (see page 23 of the CMS Medicare Value Based Purchasing (VBP) Options Paper dated April 12, 2007 AMI-8a). There is a discrepancy in the information provided in the proposed rule versus the CMS VBP Options Paper (120 minutes of hospital arrival in the proposed rule versus 90 minutes in the Options Paper). Because the VBP is being implemented beginning FY 2009, AHIMA recommends that CMS clarify and/or correct the information so it is consistent and reduces confusion for the industry.

The measures identified in the proposed rule indicate that measures identified in the FY 2008 Quality Measures table will remain in effect up to and beyond FY 2009. The measures referred to are the following:

- AMI (Beta blocker at arrival)
- HF (Left ventricular function assessment)
- PNE (Initial antibiotic received within four hours of hospital arrival)
- PNE (oxygenation assessment)
- SCIP (Prophylactic antibiotic selection for surgical patients)

The CMS VBP program to be implemented beginning FY 2009 indicates that these measures will be phased out and not included in the set for consideration under a financial-based incentive. This information is confusing to the reader as there is no indication in the *Federal Register* for the RHQDAPU program that these measures are expected to be phased out. **AHIMA recommends reconciling this information as quickly as possible so the industry has an appropriate amount of time to prepare their resources.**

IV-A-3a – Proposed New Quality Measures for FY 2009 and Subsequent Years (72FR24805)

CMS is proposing to add several quality measures for the FY 2009 RHQDAPU program. The CMS VBP Options Paper does not define these measures as being introduced during the implementation of the VBP program for FY 2009. AHIMA recommends reconciling this information as quickly as possible so that the industry has an appropriate amount of time to prepare their resources.

Using claims data as a basis for the development of measures does not provide a strong and comprehensive review of the clinical care received by a patient. Claims data provides only a cursory view into the care received and is not a complete picture by which measures should be developed. AHIMA strongly recommends that CMS reconsider using claims data as the basis for the measure development.

To which facility will the 30-day mortality measures be attributed if the patient has been hospitalized in multiple facilities (for example, patient transfers)?

IV-A-3b – Data Submission (72FR24806)

In order to be eligible for the full FY 2009 market basket update, we are proposing that hospitals will be required to submit data on 32 measures (the 27 existing measures plus the 5 proposed new measures). The CMS VBP Options Paper indicates that the organization will be phasing out five measures for FY 2009 during its implementation. AHIMA is requesting that CMS clarify how this will impact the market basket update.

IV-A-4 – Retiring or Replacing RHODAPU Program Quality Measures (72FR24807)

AHIMA strongly recommends that CMS clearly define and communicate the process by which measures will be retired and/or replaced. By providing this information to the health care community, it will allow for the appropriate planning and preparing of resources for these changes. This is especially true as the CMS VBP program is implemented during the FY 2009.

IV-A-6 – Electronic Medical Records (72FR24809)

Stating that hospitals should conform to both industry and Federal Health Architecture (FHA) standards is confusing. Due to the strong and positive work that the Certification Commission for Health Information Technology (CCHIT) is executing, it would be beneficial for the community to have a better and clearer understanding of what CMS is referring to. **AHIMA recommends that CMS provide more detailed information in regards to “industry standards” to better guide hospitals. In addition, CMS should be sure to utilize standards that have been endorsed by HITSP and are part of the CCHIT inpatient electronic health record (EHR) certification criteria.**

IV-B: Development of the Medicare Hospital Value-Based Purchasing Plan (72FR24809)

The information presented in this section regarding the CMS VBP is outdated and does not reflect the current activities occurring since the last meeting on April 12, 2007. AHIMA recommends that CMS reconcile the information presented in the Options Paper against the information currently being presented in the IPPS proposed rule with regards to the FY 2009. By reconciling this information, it will enable hospitals and vendors to better prepare and plan for the upcoming changes expected during the implementation of such a large program as the VBP.

Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare Hospital Inpatient PPS program for FY 2008. AHIMA supports CMS' goal of refining and developing a severity-adjusted DRG system. However, **we recommend that implementation of a severity-adjusted DRG system be delayed until FY 2009** in order to make an informed decision regarding selection of a DRG system based on RAND's final report of their evaluation of severity DRG systems. This will also allow the healthcare industry sufficient time to prepare for implementation of a new DRG system, and avoid the administrative burden of potentially implementing a different severity-adjusted DRG system one year after implementation of MS-DRGs.

AHIMA further recommend that CMS not make any payment adjustment to account for case mix increases attributable to coding improvements until appropriate research is conducted to determine the extent to which this would become an issue under the proposed MS-DRG system.

AHIMA urges CMS to actively promote HHS' adoption and implementation of the ICD-10-CM and ICD-10-PCS coding systems in order to ensure the availability of appropriate, consistent, and accurate clinical information reflective of patients' medical conditions and care provided. This will allow us to measure quality, implement value-based purchasing, identify hospital-acquired conditions, and adopt a DRG system that improves recognition of variances in severity of illness. With this proposed rule, we face the prospect of a rapidly changed reimbursement system without having first improved the 30-year-old classification system on which it is based, and the transaction standards necessary to carry such data. If CMS and HHS fail to meet the need for 21st century classification systems and up-to-date transaction standards, we believe the goals set out by CMS, and required by Congress, to improve the DRG system and the collection and use of quality monitoring data will fail.

AHIMA continues to recommend that CMS process all reported diagnoses and procedures. Until CMS has a full picture of the severity and services received by its Medicare patients, any system will result in inaccurate data and flawed decisions based on this data.

AHIMA stands ready to work with CMS and the healthcare industry to see that all these goals, including those of CMS for accurate payment, are met. 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, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,



Dan Rode, MBA, FHFMA
Vice President, Policy and Government Relations

cc: Sue Bowman, RHIA, CCS