



Overview of FY 2013 Medicare Hospital Inpatient Prospective Payment System Final Regulation

This overview of the fiscal year (FY) 2013 Medicare hospital inpatient prospective payment system (IPPS) final rule highlights key provisions of particular interest to health information management (HIM) professionals. The FY 2013 IPPS final rule was published in the August 31, 2012 issue of the *Federal Register* and becomes effective on October 1, 2012. Proposed changes that were not adopted in the final rule are not addressed.

CHANGES TO MEDICARE SEVERITY DRG (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (77FR53273)

FY 2013 MS-DRG DOCUMENTATION AND CODING ADJUSTMENT (77FR53273)

The final rule completes all documentation and coding adjustments for FY 2008 and FY 2009. The net effect of final documentation and coding adjustments for FY 2013 is an aggregate rate increase of 1.0 percent, a 0.8 percentage point increase from the proposed rule. The Centers for Medicare & Medicaid Services (CMS) dropped the proposed 0.8 percent documentation and coding adjustment for fiscal year (FY) 2010.

PREVENTABLE HOSPITAL-ACQUIRED CONDITIONS (HACS), INCLUDING INFECTIONS (77FR53283)

Changes to the HAC Policy for FY 2013 (77FR53285)

Diagnosis codes 999.32, Bloodstream infection due to central venous catheter, and 999.33, Local infection due to central venous catheter were added to the Vascular Catheter-Associated Infection HAC category.

Surgical Site Infection (SSI) Following Cardiac Implantable Electronic Device (CIED) procedures has been made a sub-HAC condition within the SSI HAC category subject to the HAC payment provision. These conditions will be identified through a combination of diagnosis code 996.61, Infection and inflammatory reaction due to cardiac device,

implant and graft, or 998.59, Other postoperative infection, and the procedure codes listed on page 53287 of the IPPS final rule published in the *Federal Register*.

Iatrogenic Pneumothorax with Venous Catheterization has been added as a condition subject to the HAC payment provision. This condition will be identified by a combination of diagnosis code 512.1, Iatrogenic pneumothorax, and procedure code 38.93, Venous catheterization NEC.

RTI Program Evaluation Summary (77FR53292)

Using MedPAR claims data from October 2010 through September 2011, Research Triangle, International (RTI) found that the majority of all secondary diagnoses (77.57 percent) were reported with a Present on Admission (POA) indicator of “Y,” meaning the condition was POA. Of the 287,993 discharges with a HAC-associated diagnosis as a secondary diagnosis, 3,006 discharges ultimately resulted in MS-DRG reassignment. The four HAC categories that had the most discharges resulting in MS-DRG reassignment were: (1) Falls and Trauma; (2) Pulmonary Embolism and DVT Orthopedic (Orthopedic PE/DVT); (3) Pressure Ulcer Stages III & IV; and (4) Catheter-Associated Urinary Tract Infection (CAUTI).

The total net savings calculated for October 2010 through September 2011 was approximately \$19.4 million. The three HACs with the largest number of discharges resulting in MS-DRG reassignment, Falls and Trauma, Orthopedic PE/DVT, and Pressure Ulcer Stages III & IV, generated \$17.5 million of net savings for the fiscal year. CMS noted that a decrease over time in the number of discharges where these conditions are not POA is a desired consequence [of the HAC payment policy], and so the estimated net savings would likely decline as the number of such discharges decline.

The RTI detailed report can be accessed at: <http://www.rti.org/reports/cms>.

CHANGES TO SPECIFIC MS-DRG CLASSIFICATIONS (77FR53303)

Influenza with Pneumonia (77FR53306)

Cases with a principal diagnosis code of 487.0, Influenza with pneumonia, with a secondary diagnosis code of one of the following pneumonia codes, have been reassigned from MS-DRGs 193, 194, and 195 (Simple pneumonia and Pleurisy with MCC, with CC, or without CC/MCC, respectively) to MS-DRGs 177, 178, and 179 (Respiratory Infections and Inflammations with MCC, with CC, and without MCC/CC, respectively): 482.0, 482.1, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, and 482.89.

Endovascular Implantation of Branching or Fenestrated Grafts in Aorta
(77FR53310)

Procedure code 39.78, Endovascular implantation of branching or fenestrated graft(s) in aorta, has been reassigned from MS-DRGs 252, 253, and 254 (Other Vascular Procedures with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 237 and 238 (Major Cardiovascular Procedures with MCC and without MCC, respectively).

Medicare Code Editor (MCE) Changes: MCE New Length of Stay Edit for Continuous Invasive Mechanical Ventilation for 96 Consecutive Hours or More
(77FR53313)

A new length of stay edit has been created for procedure code 96.72, Continuous invasive mechanical ventilation for 96 consecutive hours or more, when reported on a claim with a length of stay less than 4 days. Claims containing procedure code 96.72 with a length of stay less than 4 days will be returned to the provider for validation and resubmission. Detailed instructions will be issued in a future Change Request (CR) prior to the implementation date.

It was brought to CMS' attention that a number of hospitals may be inaccurately reporting code 96.72. A patient with a length of stay less than 4 days who received continuous mechanical ventilation should not have this procedure code reported on the claim. CMS acknowledged that there are particular circumstances, such as patients receiving observation services who may require continuous mechanical ventilation, it is possible to have procedure code 96.72 reported on the claim with a length of stay of less than 4 days.

MCE Changes: Sleeve Gastrectomy Procedure for Morbid Obesity (77FR53314)

Effective October 1, 2011, procedure code 43.82, Laparoscopic vertical (sleeve) gastrectomy, was created and designated as a noncoverage procedure in the MCE. A Decision Memo related to Bariatric Surgery for the Treatment of Morbid Obesity was issued effective June 27, 2012, which describes a change in coverage to Medicare beneficiaries for this procedure. [Click here](#) to access information related to this decision memo.

As the noncovered procedure edit for procedure code 43.82 is no longer valid, it has been removed from the MCE. Instructions in the form of a Change Request will be issued prior to October 1, 2012. Also, updates to the Medicare National Coverage Determinations Manual, Section 100.1, Nationally Noncovered Indications for Bariatric Surgery for Treatment of Morbid Obesity, will be revised to reflect this change in coverage.

Suggested Changes to the MS-DRG Severity Levels for Diagnosis Codes for FY 2013: Protein-Calorie Malnutrition (77FR53316)

The severity level for diagnosis codes 263.0, Malnutrition of moderate degree, and 263.1, Malnutrition of mild degree, has been changed from a non-CC to a CC.

Suggested Changes to the MS-DRG Severity Levels for Diagnosis Codes for FY 2013: Chronic Total Occlusion of Artery of the Extremities (77FR53318)

The severity level for diagnosis code 440.4, Chronic total occlusion of artery of the extremities, has been changed from a non-CC to a CC.

Suggested Changes to the MS-DRG Severity Levels for Diagnosis Codes for FY 2013: Acute Kidney Failure with Other Specific Pathological Lesion in Kidney (77FR53318)

The severity level of diagnosis code 584.8, Acute kidney failure with other specified pathological lesion in kidney, has been changed from an MCC to a CC.

Changes to the ICD-9-CM Coding System, Including Discussion of the Replacement of the ICD-9-CM System With the ICD-10-CM and ICD-10-PCS Systems in FY 2014 (77FR53322)

As a result of the partial code freeze, just one new ICD-9-CM procedure code, 00.95 (Injection or infusion of glucarpidase), became effective October 1. There are no new, revised, or deleted ICD-9-CM diagnosis codes and no revised or deleted ICD-9-CM procedure codes.

ADD-ON PAYMENTS FOR NEW SERVICES AND TECHNOLOGIES (77FR53343)

FY 2013 Status of Technologies Approved for FY 2012 Add-On Payments: Auto Laser Interstitial Thermal Therapy (AutoLITT™) System (77FR53345)

New technology add-on payments will continue to be made for the AutoLITT™ system in FY 2013.

FY 2013 Applications for New Technology Add-On Payments: Glucarpidase (Trade Brand Voraxaze®) (77FR53346)

Voraxaze® has been approved for new technology add-on payments in FY 2013. Cases of Voraxaze® will be identified with procedure code 00.95, Injection or infusion of glucarpidase.

FY 2013 Applications for New Technology Add-On Payments: DIFICID™ (Fidaxomicin) Tablets (77FR53350)

In the past, CMS has not considered drugs that are only taken orally to be eligible for consideration for new technology add-on payments because there is no procedure associated with these drugs and therefore no ICD-9-CM code(s). In this final rule, CMS revised its policy to allow the use of National Drug Codes (NDCs) to identify oral medications that have no inpatient procedure for the purposes of new technology add-on payments.

DIFICID™ (Fidaxomicin) has met all of the criteria for the new technology add-on payment policy and therefore has been approved for new technology add-on payments in FY 2013. Cases will be identified with ICD-9-CM diagnosis code 008.45, Intestinal infection due to Clostridium Difficile, in combination with NDC code 52015-0080-01. Providers must code the NDC on the 837i Health Care Claim Institutional form in conjunction with ICD-9-CM code 008.45 in order to receive the new technology add-on payment. Further guidance will be issued after the final rule on how to code the NDC code on the 837i form.

FY 2013 Applications for New Technology Add-On Payments: Zenith® Fenestrated Abdominal Aortic Aneurysm (AAA) Endovascular Graft (77FR53360)

The Zenith® Fenestrated AAA Endovascular Graft has been approved for new technology add-on payments in FY 2013. Cases will be identified by ICD-9-CM procedure code 39.78, Endovascular implantation of branching or fenestrated graft(s) in aorta.

OTHER DECISIONS AND CHANGES TO THE IPPS FOR OPERATING COSTS AND GME (GRADUATE MEDICAL EDUCATION) COSTS (77FR53374)

HOSPITAL READMISSIONS REDUCTION PROGRAM (77FR53374)

Section 1886(q) of the Affordable Care Act establishes the “Hospital Readmissions Reduction Program,” effective for discharges from an “applicable hospital” beginning on or after October 1, 2012, under which payments to those applicable hospitals may be reduced to account for certain excess readmissions. In the FY 2012 IPPS final rule, the applicable conditions for this program were finalized. They are heart failure, acute myocardial infarction, and pneumonia. The definition of “readmission,” as finalized in the FY 2012 IPPS final rule, is an admission occurring when a patient is discharged from an applicable hospital and then admitted to the same or another acute care hospital, that is, another applicable hospital, within a specified time period (30 days) from the date of discharge from the initial index hospitalization.

As finalized in the FY 2012 IPPS final rule, three National Quality Forum (NQF)-endorsed, hospital risk-standardized readmission measures, which are currently in the

Hospital Inpatient Quality Reporting (IQR) Program, will be used for the Hospital Readmissions Reduction Program in FY 2013: Acute Myocardial Infarction 30-day Risk Standardized Readmission Measure (NQF #0505); Heart Failure 30-day Risk Standardized Readmission Measure (NQF #0330); and Pneumonia 30-day Risk Standardized Readmission Measure (NQF #0506). These measures include the 30-day time window, risk-adjustment methodology, and exclusions for certain readmissions. The measures define an “index hospitalization” as a hospitalization evaluated in the measure for a possible readmission within 30 days after discharge. Excluded as index hospitalization patients are those who died during the first admission, patients who have not spent at least 30 days post-discharge enrolled in Medicare fee-for-service, those who are discharged against medical advice, transfers, and multiple admissions within 30 days of a prior index admission. For the acute myocardial infarction measure, same day discharges are excluded as an index admission.

The discharge diagnoses for each applicable condition are based on a list of specific ICD–9–CM codes for that condition. These codes are listed in the *2010 Measures Maintenance Technical Report: Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-Day Risk-Standardized Readmission Measures*. They also are posted on this Web site: [http:// www.QualityNet.org](http://www.QualityNet.org).

In response to stakeholder input, CMS intends to update the condition-specific measures to permit more planned readmissions for these measures, which would not be counted as readmissions. CMS noted that they are aware of the National Uniform Billing Committee’s intention to propose a discharge status code on claims to identify planned readmissions. They would analyze its reliability, validity, and usability for identifying planned readmissions prior to considering the adoption of such a code for use in the readmission measures in the future.

QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS (77FR53502)

CMS’ goal for the future is to align the clinical quality measure requirements of the Hospital IQR Program with various other Medicare and Medicaid programs, including those authorized by the Health Information Technology for Economic and Clinical Health (HITECH) Act so that the burden for reporting will be reduced. As appropriate, they will consider the adoption of measures with electronic specifications, so that the electronic collection of performance information is part of care delivery.

CMS believes that automatic collection and reporting of data elements for many measures through electronic health records (EHRs) will greatly simplify and streamline reporting for various CMS quality reporting programs and that at a future date, such as FY 2015, hospitals will be able to switch primarily to EHR-based reporting of data for many measures that are currently manually chart-abstracted and submitted to CMS for the Hospital IQR Program.

CMS views the HAC payment adjustment program authorized by section 3008 of the Affordable Care Act and the Hospital Value-Based Purchasing (VBP) Program as being related but separate efforts to reduce HACs. The Hospital VBP Program is an incentive program that awards payments to hospitals based on quality performance on a wide variety of measures, which the program established by section 3008 of the Affordable Care Act creates a payment adjustment resulting in payment reductions for the lowest performing hospitals based on their rates of HACs.

HOSPITAL INPATIENT QUALITY REPORTING (IQR) PROGRAM (77FR53503)

Maintenance of Technical Specifications for Quality Measures (77FR53503)

CMS finalized a policy under which they will use a subregulatory process to make non-substantive updates to NQF-endorsed measures used for the Hospital IQR Program. With respect to what constitutes substantive versus non-substantive changes, they expect to make this determination on a case-by-case basis. Examples of non-substantive changes to measures might include updated diagnosis or procedure codes, medication updates for categories of medications, broadening of age ranges, and exclusions for a measure. CMS will continue to use rulemaking to adopt substantive updates made by the NQF to the endorsed measures they have adopted for the Hospital IQR Program.

Removal of Hospital IQR Program Measures for FY 2015 Payment Determination and Subsequent Years (77FR53506)

CMS removed 17 measures, one chart-abstracted and 16 claims-based, from the Hospital IQR Program. A list of the removed measures can be found on page 53509 of the final rule.

Suspension of Data Collection for the FY 2014 Payment Determination and Subsequent Years (77FR53509)

In the FY 2012 IPPS final rule, CMS suspended data collection for four measures beginning with January 1, 2012 discharges, affecting the FY 2014 payment determination and subsequent years. These four measures are: Acute Myocardial Infarction (AMI)-1 – Aspirin at Arrival; AMI-3 – ACEI/ARB for left ventricular systolic dysfunction; AMI-5 – Beta blocker prescribed at discharge; Surgical Care Improvement Project (SCIP) INF-6 – Appropriate Hair Removal.

These measures were suspended, rather than removed, because although CMS' analysis indicated these measures are topped-out (that is, their performance is uniformly high nationwide, with little variability among hospitals), CMS recognized some commenters' belief that the processes assessed by the measures were tied to better patient outcomes, and that removal of the measures from the program may result in declines in performance and hence worse outcomes.

The suspension of data collection for these four measures will be continued unless CMS has evidence that performance on the measures is in danger of declining.

Measures for the FY 2015 and FY 2016 Hospital IQR Program Payment Determinations: Process for Retention of Hospital IQR Program Measures Adopted in Previous Payment Determinations (77FR53512)

CMS adopted a measure retention policy whereby, when measures are adopted for the Hospital IQR Program beginning with a payment determination and subsequent years, these measures will automatically be adopted for all subsequent payment determinations unless CMS proposes to remove, suspend, or replace the measures.

Measures for the FY 2015 and FY 2016 Hospital IQR Program Payment Determinations: New Survey-Based Measure Items for Inclusion in the HCAHPS Survey Measure for the FY 2015 Payment Determination and Subsequent Years (77FR53513)

The NQF-endorsed 3-Item Care Transition Measure (CTM-3) (NQF #0228) has been added to the existing Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

Measures for the FY 2015 and FY 2016 Hospital IQR Program Payment Determinations: New Claims-Based Measures for the FY 2015 Payment Determination and Subsequent Years (77FR53516)

The Hospital IQR Program measures for the FY 2015 payment determination and subsequent years, including newly-adopted measures, can be found on the table on pages 53530-31 in the IPSS final rule published in the *Federal Register*.

Hip/Knee Complication: Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) (77FR53516)

A new claim-based measure for Hip/Knee Complication: Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) has been adopted for the FY 2015 payment determination and subsequent years. The measure methodology identifies eligible index admissions using ICD-9-CM procedure codes 81.51, Total hip arthroplasty, and 81.54, Total knee arthroplasty, in Medicare Part A inpatient claims data. The measure specifications will be updated yearly and will be specified using ICD-10-CM.

Hip/Knee Readmission: Hospital-Level 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) (77FR53519)

A measure for Hip/Knee Readmission: Hospital 30-Day All-Cause Readmission Following Elective Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA) has also been adopted for the Hospital IQR Program for the FY 2015 payment determination and subsequent years. Eligible index admissions would be identified using one of the total hip and knee arthroplasty ICD-9-CM procedure codes noted above.

Hospital-Wide Readmission (77FR53521)

A Hospital-Wide Readmission measure has been adopted in order to assess the hospital-level, risk-standardized rate of unplanned, all-cause readmissions after admissions for any eligible condition within 30 days of hospital discharge. One year of data will be used to calculate the measure rate for this measure. For this measure, a patient is considered to have been readmitted if they experience one or more inpatient admissions within the 30 days after being discharged from an initial inpatient admission, whether the patient was readmitted to the same hospital or another. The measure excludes patients who died during the index admission; patients who were transferred to another acute care hospital; patients who were discharged against medical advice; patients who died within the 30-day post-discharge period; admissions for medical treatment of cancer, for primary psychiatric disease, or for physical rehabilitation and prosthetic services.

The Hospital-Wide Readmission measure identifies “planned readmissions” in claims data that will not count as readmissions in the measure using an algorithm that identifies readmissions that are likely to be planned as opposed to readmissions due to probable complications. The algorithm is based on two main principles: planned readmissions are those in which one of a pre-specified list of procedures took place; and admissions for acute illness or for complications of care are likely not “planned.” Procedure codes and discharge diagnosis categories for each readmission will be used to identify planned readmissions. The procedure categories considered planned depending on the discharge condition and the discharge condition categories considered acute or complications of care are listed in tables on pages 53524-25 in the FY 2013 IPPS final rule published in the *Federal Register*. These procedures and conditions are defined by the Agency for Healthcare Research and Quality (AHRQ) Clinical Classification Software (CCS), which is a widely used and accepted method of grouping patients into diagnostic and procedural categories.

New Chart-Abstracted Measure: Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation (77FR53528)

A new chart-abstracted measure, Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation, has been added for the FY 2015 payment determination and subsequent years.

CMS believes that a reduction in the number of nonmedically indicated elective deliveries greater than or equal to 37 weeks and less than 39 weeks gestation will result in a substantial decrease in neonatal morbidity and mortality, as well as a significant savings in healthcare costs.

Measures for the FY 2015 and FY 2016 Hospital IQR Program Payment Determinations: Hospital IQR Program Quality Measures for the FY 2016 Payment Determination and Subsequent Years (77FR53531)

The Safe Surgery Checklist Use measure has been adopted for the FY 2016 payment determination and subsequent years. For this structural measure, a hospital inpatient department must indicate whether or not it uses a safe surgery checklist for its surgical procedures that includes safe surgery practices during each of the three critical perioperative periods. The measure does not require a hospital to report whether it uses a checklist in connection with each individual inpatient procedure.

The Hospital IQR Program measures for the FY 2016 payment determination and subsequent years are listed on pages 53533-34 of the IPPS final rule published in the *Federal Register*.

Supplements to the Chart Validation Process for the Hospital IQR Program for the FY 2015 Payment Determination and Subsequent Years: Selection and Sampling of HAI Measures for Validation (77FR53542)

CMS finalized the proposal to validate the Central Line-Associated Blood Stream Infection (CLABSI), CAUTI, and SSI measures by identifying records that are “candidate HAI events.” In order to facilitate validation for CLABSI and CAUTI, hospitals will be required to report the beneficiary’s Health Insurance Claim Number (HICN) on the positive blood culture or positive urine culture template for all ICU patients that have a positive blood or urine culture. A positive blood or urine culture has also been slightly redefined.

For validation of the SSI measure, candidate events will be selected from among Medicare fee-for-service claims for patients who have had colon surgeries or abdominal hysterectomies. For each Medicare fee-for-service patient who had a relevant surgery in the period under validation, a CMS contractor will review the index claim (the one denoting the surgery) and all subsequent readmissions to the index hospital within a 30 day post-discharge period. Candidate SSI events will be identified by discharge diagnoses that might indicate infection on the index claim and all inpatient claims in the 30 days post-discharge. Cases identified during readmission to hospitals other than the index hospital would be excluded from SSI validation. A list of the ICD-9-CM diagnosis codes that will be used to identify candidate SSI events can be found on pages 53546-57 of the IPPS final rule published in the *Federal Register*.

HOSPITAL VALUE-BASED PURCHASING (VBP) PROGRAM (77FR53567)

Measures for the FY 2015 Hospital VBP Program (77FR53582)

SCIP-Inf-10: Surgery Patients with Perioperative Temperature Management has been removed from the FY 2015 Hospital VBP Program because it is topped-out.

CMS finalized the FY 2015 Hospital VBP Program measure set as proposed, with the exception of AMI-10: Statin Prescribed at Discharge, which is topped-out.

General Process for Hospital VBP Program Measure Adoption for Future Program Years (77FR53592)

In order to facilitate measure adoption for the Hospital VBP Program for future years and further align the Hospital VBP Program with the Hospital IQR Program, measures from the prior program year will be re-adopted for each successive program year, unless proposed and finalized otherwise.

Measures and Domains for the FY 2016 Hospital VBP Program (77FR53592)

Three 30-day mortality measures and PSI-90: Complication/Patient Safety for Selected Indicators (Composite), have been retained for FY 2016 Hospital VBP Program. Also, since CMS finalized the proposal to automatically re-adopt measures from year to year, the other FY 2015 measures will also become part of the FY 2016 measure set (with the exception of the CLABSI measure) unless CMS proposes otherwise in future rulemaking. CMS anticipates adopting additional measures for the FY 2016 Hospital VBP Program in future rulemaking.

Performance Standards for the FY 2015 Hospital VBP Program Measures (77FR53599)

CMS noted that they are aware that once the ICD-10-CM/PCS coding transition is completed, they will be faced with comparing hospitals' performance from baseline periods coded using ICD-9-CM with performance periods coded using ICD-10-CM/PCS. CMS will closely monitor future measure specification updates incorporating ICD-10 codes into future measure proposals. They will also closely monitor how measure rates change following ICD-10 adoption in their future performance standards and measure proposals.

Adopting Performance Periods and Standards for Future Program Years
(77FR53603)

Performance periods and performance standards will be updated for future program years via notice on the CMS Web site or another publicly-available Web site.

**QUALITY IMPROVEMENT ORGANIZATION (QIO)
REGULATION CHANGES RELATED TO PROVIDER AND
PRACTITIONER MEDICAL RECORD DEADLINES AND
CLAIMS DENIALS** (77FR53664)

QIOs have historically experienced difficulty in obtaining medical information in a timely manner from providers and even more difficulty obtaining this information in a timely manner from practitioners. Therefore, CMS adopted several regulatory changes to more clearly convey the responsibilities of providers and practitioners in submitting medical information and to specify the QIO's authority if the information is not received.

For questions concerning this overview or the FY 2013 IPPS final rule, contact Sue Bowman, AHIMA's Senior Director of Coding Policy and Compliance, at sue.bowman@ahima.org.

Resources

The final rule regarding the fiscal year 2013 revisions to the Medicare hospital inpatient prospective payment system can be found in the August 31, 2012 issue of the *Federal Register* located at: <http://www.gpo.gov/fdsys/pkg/FR-2012-08-31/pdf/2012-19079.pdf>.

AHIMA's letter to CMS regarding the proposed rule for FY 2013 revisions to the Medicare hospital inpatient prospective payment system can be found on the Advocacy and Public Policy page of the AHIMA Web site, under Comments & Analyses: <http://www.ahima.org/downloads/pdfs/advocacy/AHIMARespondstoCMSProposedChangesToTheMedicareHospitalIPPSandFiscalYear2013RatesRevised.pdf>.