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June 22, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1588-P**
PO Box 8011
Baltimore, Maryland 21244-1850

Dear Administrator Tavenner:

On behalf of the American Health Information Management Association (AHIMA), I am responding to the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the Medicare Hospital Inpatient Prospective Payment Systems (IPPS) and fiscal year 2013 Rates, as published as a notice of proposed rulemaking (NPRM) in the May 11, 2012 *Federal Register* (CMS-1588-P).

AHIMA is a nonprofit professional association representing more than 64,000 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. Among AHIMA's member professionals are individuals who have engaged in ongoing in-depth education and obtained one or more certifications in the coding of health records by applying classification standards, official guidance, and AHIMA's standards for ethical coding. This response to the May 11 NPRM was done in consultation with a group of credentialed professionals and AHIMA staff.

As part of our effort to promote consistent coding practices, AHIMA serves as 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 development of official guidance associated with the proper use of the ICD-9-CM, ICD-10-CM, and ICD-10-PCS code sets.

AHIMA members are also deeply involved with the development and analysis of healthcare secondary reporting data including value sets associated with quality measurement and in the development, planning, implementation and management of electronic health records.

Our detailed comments and rationale on the IPPS NPRM are below.

II. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights (77FR27886)

II-F-5a – Preventable Hospital-Acquired Conditions (HACs), Including Infections: Proposed Additional Diagnosis Codes to Existing HACs (77FR27894)

AHIMA supports adding diagnosis codes 999.32, Bloodstream infection due to central venous catheter, and 999.33, Local infection due to central venous catheter, to the Vascular Catheter-Associated Infection HAC category.

II-F-5b – Preventable Hospital-Acquired Conditions (HACs), Including Infections: Proposal to Add New HAC Condition – Surgical Site Infection (SSI) Following Cardiac Implantable Device (CIED) Procedures (77FR27894)

AHIMA agrees with CMS that "surgical site infection following cardiac implantable device" meets the criteria for inclusion on the HAC list and that this condition can be captured with the combination of diagnosis and procedure codes identified in the NPRM.

II-F-5c – Preventable Hospital-Acquired Conditions (HACs), Including Infections: Proposal to Add New HAC Condition – Iatrogenic Pneumothorax with Venous Catheterization (77FR27896)

We are concerned about the proposal to use the combination of procedure code 38.93, Venous catheterization NEC, and diagnosis code 512.1, Iatrogenic pneumothorax, to identify iatrogenic pneumothorax with venous catheterization. Procedure code 38.93 is not routinely or consistently captured in hospitals. Also, the presence of both procedure code 38.93 and diagnosis code 512.1 does not necessarily mean they are related. Venous catheterization is a very common procedure.

II-G-1-4 – Proposed Changes to Specific MS-DRG Classifications (77FR27898)
We support CMS' recommendations regarding proposed changes to specific MS-DRG classifications.

II-G-5 – Proposed Medicare Code Editor (MCE) Changes (77FR27905)

AHIMA supports the creation of a new MCE edit in which claims found to have procedure code 96.72, Continuous invasive mechanical ventilation for 96 consecutive hours or more, with a length of stay less than 4 days would be returned to the provider for validation and resubmission, in order to address possible errors in the use of this code.

II-G-7b (2) – Suggested Changes to MS-DRG Severity Levels for Diagnosis Codes for FY 2013 (77FR27907)

We support CMS' recommendations regarding proposed changes to MS-DRG severity levels for certain diagnosis codes.

II-I-4b – FY 2013 Applications for New Technology Add-On Payments – DIFICID™ (Fidaxomicin) Tablets (77FR27939)

We agree with CMS' rationale regarding why oral medications should not be considered eligible for new technology add-on payments. As CMS noted, there is no "procedure" associated with administered oral medications, so therefore, there is no ICD-9-CM procedure code to identify administration of oral medications.

IV-A – Hospital Readmission Reduction Program (77FR27955)

CMS should widely publicize the risk adjustment variables that will be used to calculate readmission rates to ensure widespread awareness. Currently, this information is not easy to locate. The comorbidities included in the risk adjustment variables may not all be consistently coded at the present time.

VIII. Proposed Quality Data Reporting Requirements for Specific Providers and Suppliers (77FR28032)

During this era of converging program requirements in healthcare (Meaningful Use, Quality Reporting, Value-based Purchasing), AHIMA applauds and urges continued efforts to align the use of measures across federal and state Medicaid initiatives so as to decrease the burden of programs requiring collection/reporting/attestation of data. We urge the consolidation into ONE overarching reporting program to decrease the burden on healthcare providers/facilities.

AHIMA commends and recommends the continued selection of measures for the Quality Reporting Programs and the Value-based Purchasing Program to be based upon the Measure Application Partnership recommendations of National Quality Forum (NQF) endorsed measures inclusive of the criteria that the measure be endorsed for the specified provider organization/facility setting to which it is applied. Further, we strongly urge that measures used in the Value-based Purchasing Program be NQF endorsed before the performance measurement period begins.

AHIMA applauds the efforts to obtain information electronically in the future utilizing eMeasures. We urge the continued efforts to balance the burden of measures which require manual chart abstraction with the potential for quality improvement of the healthcare delivery system. AHIMA urges the prioritization of conversion of measures to e-Measures and in addition, urges the prioritization of conversion to ICD10-CM/PCS where applicable. There is a growing awareness regarding the difficulties and challenges to conversion. We urge CMS to carefully balance the need/cost to collect information in the current format with the potential lack of comparability of results in a new format. AHIMA urges CMS to carefully monitor and communicate the progression of conversion and comparability of measures.

We urge that an expedited review/revision of the hierarchical logistic modeling (HLM) methodology incorporating ICD-10-CM/PCS be performed. The HLM has been determined to appropriately account for the types of patients a hospital treats, the number of patients it treats, and the quality of care it

provides. It is used to estimate risk-standardized complication rates and is specified for NQF-endorsed CMS inpatient outcome measures.

VIII-A-1b – Hospital Inpatient Quality Reporting (IQR) Program – Maintenance of Technical Specifications for Quality Measures (77FR28033)

AHIMA agrees with the proposal to allow CMS to update NQF endorsed measures that do not substantially change the nature of the measure using a subregulatory process as outlined with timely updates clearly communicated and easily accessible via the QualityNet Web site. We consider conversion of measures to use ICD-10-CM/PCS and eMeasure format to be a substantial change which should follow current proposed rulemaking processes.

VIII-A-2d – Removal and Suspension of Hospital IQR Program Measures – Suspension of Data Collection for the FY 2014 Payment Determination and Subsequent Years (77FR28036)

We request clarification on the methodology that will be used to determine if the measures are declining in performance.

VIII-A-3b (2)(A) – Proposed New Survey-Based Measure Items for Inclusion in the HCAHPS Survey Measure for the FY 2015 Payment Determination and Subsequent Years (77FR28038)

AHIMA does not recommend the addition of new items for the HCAHPS Survey. The reliability of data for "emergency room admission" as point of origin for hospital patients will be more reliable when collected and reported by the facility.

We believe it is inappropriate for a non-clinician to collect a self-reported mental health item via a non-face-to-face survey that does not include immediate clinician follow-up. In addition to clinical concerns, data from such an item requires thorough delineation of use and Privacy Protection to prevent unintended consequences.

VIII-A-3b (2)(B) – Proposed New Claims-Based Measures for the FY 2015 Payment Determination and Subsequent Years (77FR28039)

AHIMA respectfully requests that the ICD-10-CM/PCS versions of measure specifications be published in the final rule.

VIII-A-3b (2)(C) – Proposed New Chart-Abstracted Measure: Elective Delivery Prior to 39 Completed Weeks Gestation: Percentage of Babies Electively Delivered Prior to 39 Completed Weeks Gestation (77FR28046)

This chart-abstracted measure should be converted to use ICD-9-CM **and** ICD-10-CM/PCS codes before inclusion in the Hospital IQR Program. Rigorous review of testing results should be performed to ensure measure rates before and after the ICD-10-CM/PCS transition date are comparable.

VIII-A-3c – Proposed Hospital IQR Program Quality Measures for the FY 2016 Payment Determination and Subsequent Years (77FR28048)

AHIMA concurs with the addition of the Safe Surgery Checklist structural measure, pending availability of specifications.

VIII-A-6 – Proposed Supplements to the Chart Validation Process for the Hospital IQR Program for the FY 2015 Payment Determination and Subsequent Years (77FR28053)

We support the outlined changes to the validation process but request clarification regarding the resolution process of any discrepancies or disputes by a provider before public display.

VIII-B-3b – Proposed PPS-Exempt Hospital Quality Reporting (PCHQR) Program – Proposed PCHQR Program Quality Measures for FY 2014 Program and Subsequent Program Years (77FR28061)

Although the healthcare-associated infections (HAIs) measures are NQF endorsed, AHIMA urges delay in the use of HAI measures until the reliability and validity of measures are fully tested in the specific setting of PPS-Exempt Cancer Hospital with immunocompromised patients.

VIII-C-8 – Hospital Value-Based Purchasing (VBP) Program – Proposed Measures for the FY 2015 Hospital VBP Program (77FR28078)

AHIMA urges postponement of inclusion of Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicator (PSI) #90 and the Medicare Efficiency Measure in the Value-based Purchasing Program until endorsement by NQF.

VIII-C-10 – Hospital Value-Based Purchasing (VBP) Program – Proposed Performance Periods and Baseline Periods for the FY 2015 Hospital VBP Program (77FR28082)

We agree with the restructuring of domains to align with the National Quality Strategy. The domain "Clinical Care" should include subdomains of "process" and "outcomes" with separate weighting. Weights should be reconsidered as measure sets evolve and mature, and we recommend a decrease in the weighting of patient experience from thirty percent (30%).

VIII-D-5 – Long-Term Care Hospital Quality Reporting (LTCHQR) Program – Proposed Timeline for Data Submission Under the LTCHQR Program for the FY 2015 Payment Determination (77FR28100)

AHIMA believes the reduction of the submission deadline from 135 to 45 days after each quarter is premature and recommends this be revisited when there is a substantial shift to the eMeasure format.

VIII-F-4b – Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program – Proposed Quality Measures Beginning with FY 2014 Payment Determination and Subsequent Years
(77FR28107)

We concur with the proposal to collect aggregate data and requests clarification regarding the data validation methodology.

VIII-F-7e – Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program – Proposed Population, Sampling, and Minimum Case Threshold for FY 2014 and Subsequent Years
(77FR28114)

AHIMA agrees with the importance of industry-wide quality improvement, but due to the administrative burden of data collection, we do not recommend collection of inpatient psychiatric facility data on all patients until there is a shift to eMeasures.

Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare Hospital IPPS program for FY 2013. AHIMA is committed to working 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 Sue Bowman, Senior Director for Coding Policy and Compliance at (312) 233-1115 or sue.bowman@ahima.org. In Sue's 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 senior director for federal affairs, Allison Viola, at (202) 659-9440 or allison.viola@ahima.org.

Sincerely,

Lynne Thomas Gordon, MBA, RHIA
Chief Executive Officer

cc: Sue Bowman, MJ, RHIA, CCS
Dan Rode, MBA, CHPS, FHFMA
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