233 N. Michigan Ave.,21st Fl.
Chicago, IL 60601

phone » (312) 233-1100
fax » (312) 233-1090
web » www.ahima.org

June 25, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1599-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 2014 Rates, as published as a notice of proposed rulemaking (NPRM) in the May 10, 2013 *Federal Register* (CMS-1599-P).

AHIMA is a nonprofit professional association representing more than 67,000 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 10 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. We consider conversion of a measure to use ICD-10-CM/PCS to be a substantive change which should follow current proposed rulemaking processes. **We respectfully request clarification regarding the publication, preview, and**

comment period for ICD-9-CM to ICD-10-CM/PCS mappings for all measures for use as specified in this rule.

Since the development of DRGs in the early 1980s, the development, revisions, and management of ICD-9-CM classifications has been announced in the Medicare IP-PPS NPRM. As the healthcare industry has considered a replacement for ICD-9-CM it became clear that many in the industry did not understand the various purposes for the classification code beyond reimbursement and even after the decade of debates many still do not understand the value of the ICD-10-related code sets and the value of the documentation that supports these codes for purposes including public health, quality measurement, research, and so on. To put the forthcoming ICD-10-CM and ICD-10-PCS classifications in line with other data and information goals and efforts of the Department of Health and Human Services (HHS), **AHIMA respectfully recommends that the publication of the codes set additions, changes, and other associated information such as guidelines and other requirements under HIPAA be published in a separate NPRM and Final Rule, and not continue to be included in the Medicare IP PPS NPRM and Final Rule, effective for FY2015**

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 (78FR27502)

II-G-1-6 – Proposed Changes to Specific MS-DRG Classifications (78FR27512)

We support CMS' recommendations regarding proposed changes to specific MS-DRG classifications.

II-G-7 – Proposed Medicare Code Editor (MCE) Changes (78FR27520)

AHIMA supports CMS' proposed removal of ICD-9-CM diagnosis codes 751.1, 751.2, and 751.61 from the pediatric age conflict edit.

AHIMA also supports the addition of new discharge status codes approved by the National Uniform Billing Committee (NUBC) to the CMS Grouper and MCE logic. We request that CMS clarify if it plans to use the new discharge status codes for planned acute care hospital inpatient readmissions in any way. Based on the description of a planned readmission algorithm in this proposed rule, it appears as though CMS is planning to use an algorithm to identify planned readmissions as part of the Hospital Readmissions Reduction Program, rather than relying on the planned readmission discharge status codes reported on claims. Does this mean that CMS does not plan to use the planned readmission discharge status codes for any purpose? If CMS does plan to use these discharge status codes in some way, AHIMA recommends that CMS work with the NUBC to develop additional guidance on their proper use. For example, it is not clear if there is a limitation on the timeframe when the planned readmission is expected to occur in order to use these discharge status codes. It is also not clear whether these codes are limited to planned readmissions related to the current admission. For example, the plan of care might

mention that the patient is returning in the future for scheduled treatment of a condition unrelated to the current hospitalization.

II-G-9 – Complications or Comorbidity (CC) Exclusions List (78FR27521)

AHIMA supports CMS' recommendations regarding suggested changes to the MS–DRG diagnosis codes for FY 2014.

IX. Proposed Quality Data Reporting Requirements for Specific Providers and Suppliers (78FR27676)

IX-A-1-c – Proposed Public Display of Quality Measures (78FR27678)

AHIMA supports the proposal to display the individual four indicators for PS-90 composite measure. We respectfully request a multi-stakeholder consensus process be used for design of graphical display of data for patients and consumers of healthcare and modification to the Hospital Compare display.

IX-A-2-c –Proposed Removal of Hospital IQR Program Measures for the FY 2016 Payment Determination and Subsequent Years (78FR27680)

AHIMA commends the efforts of CMS to continually review measures to ensure conformance to criteria of the program. AHIMA supports the removal of measures as proposed, under this section.

IX-A-5 –Proposed Refinements to Existing Measures in the Hospital IQR Program (78FR27683)

AHIMA supports the refinements to Measures in the Hospital IQR Program as supported by the Measure Application Partnership (MAP) pre-rule making recommendations.

IX-A-6 – Proposed Additional Hospital IQR Program Measures for the FY 2016 Payment Determination and Subsequent Years (78FR27684)

AHIMA urges the use of National Quality Forum (NQF) endorsed measures which have been reviewed and recommended for use in federal programs by the MAP. The NQF endorsement procedure ensures the critical review of the science of a measure and its development through a multi-stakeholder, transparent, consensus process. The MAP pre-rulemaking procedure ensures the critical review for appropriateness of use in federal programs through a multi-stakeholder, transparent consensus process. We urge the use of this tiered review process for selection of measures in federal programs.

IX-A-6-c – Proposed Hospital 30-day, All-Cause Risk-Standardized Rate of Readmission Following Acute Ischemic Stroke (Stroke Readmission) Measure (78FR27686)

AHIMA does not support the inclusion of this measure as it is not endorsed by NQF nor recommended by the MAP.

IX-A-6-d – Proposed Hospital 30-Day, All-Cause Risk-Standardized Rate of Mortality Following an Admission for Acute Ischemic Stroke (Stroke Mortality) Measure (78FR27689)

AHIMA does not support the inclusion of this measure as it is not endorsed by NQF nor recommended by the MAP.

IX-A-7- Electronic Clinical Quality Measures (78FR27694)

AHIMA supports the CMS proposal to make electronic reporting in CY2014 voluntary. We urge CMS and ONC to align efforts to verify through demonstration projects the comparability of results of manually abstracted measures with electronically specified/EHR extracted measures. AHIMA further urges the development of a results validation program to include a certification requirement for 3rd party auditors.

IX-A-8-c Proposed Data Submission Requirements for Chart-Abstracted Measures (78FR27696)

AHIMA urges a measured approach to the adoption of additional quality measures and respectfully requests concomitant alignment with Meaningful Use. We further urge CMS and ONC to include the vendor community when working with measure stewards and developers in the development of new measure concepts, and conduction of pilot, reliability and validity testing.

IX-A-9-d- Proposed Data Submission Requirements for Quality Measures That May Be Voluntarily Electronically Reported for the FY2016 Payment Determination (78FR27696)

AHIMA commends the paced transition for voluntarily reporting electronically for 2014 of 1 quarter of data. We respectfully request that hospitals pioneering these efforts be recognized on the Hospital Compare site.

. **IX-B-5-b-(3)– Patient Experience of Care Survey** (78FR27713)

AHIMA supports the recommendation of the MAP for the cancer module of the HCAHPS survey to be submitted for endorsement as soon as possible and we further recommend further testing to be done to address the cancer population, palliative/end-of-life-care, and to include outpatient services before inclusion in the PCHQR program.

IX-C-8-b-(1) – Proposed Quality Measure#1: National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measures (NQF #1716) (78FR27720)

AHIMA supports the recommendation of the MAP for this measure to be specified and tested in the Long Term Care Hospital setting before inclusion in the program.

IX-C-8-b-(2) - Proposed Quality Measure #2: National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure (NQF #1717) (78FR27725)

AHIMA supports the recommendation of the MAP for this measure to be specified and tested in the Long Term Care Hospital setting before inclusion in the program.

IX-D-5-b-(1) – *SUB*-1: Alcohol Use Screening (NQF Review Pending) (78FR27737)

AHIMA supports the recommendation of the MAP for inclusion of this measure in the IPFQR program to be contingent upon NQF endorsement.

IX-D-5-b-(1) – *SUB*-4: Alcohol and Drug Use: Assessing Status After Discharge (NQF Review Pending) (78FR27738)

AHIMA supports the recommendation of the MAP for inclusion of this measure in the IPFQR program to be contingent upon NQF endorsement.

Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare Hospital IPPS program for FY 2014. 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 of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org. Questions related to quality measures can be submitted to Lisa Brooks Taylor director of HIM Practice at (312) 233-1534 or lisa.taylor@ahima.org. In Ms Bowman or Ms Taylor's absence, please feel free to contact AHIMA's vice president of Advocacy and Policy, Dan Rode, at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Lynne Thomas Gordon, MBA, RHIA
Chief Executive Officer

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