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March 17, 2011

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2400-P
P.O. Box 8016
Baltimore, MD 21244-1850

Dear Dr. Berwick,

The American Health Information Management Association (AHIMA) would like to submit to you comments and recommendations on the request for information published in the *Federal Register* Thursday, February 17, 2011 regarding the notice of proposed rulemaking to implement in the Medicaid Program; Payment Adjustment for Provider-Preventable Conditions including Healthcare-Acquired Conditions [76FR9283].

AHIMA is a not-for-profit professional association representing more than 61,000 health information management (HIM) professionals who work throughout the healthcare industry. AHIMA's HIM professionals are educated, trained, and certified to serve the healthcare industry and the public by managing, analyzing, reporting, and utilizing data vital for patient care, while making it accessible to healthcare providers and appropriate researchers when it is needed most. We respectfully submit our comments as our members are and will continue to be active participants in the implementation, maintenance, and compliance of this program.

If AHIMA can provide further information or if there are any questions regarding our recommendations, please contact me at (202) 659-9440 or allison.viola@ahima.org, or Dan Rode, vice president, policy and government relations, at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Allison Viola, MBA, RHIA
Director, Federal Relations

cc: Dan Rode, MBA, CHPS, FHFMA, Vice President, Policy and Government Relations
Sue Bowman, RHIA, CCS, Director, Coding Policy and Compliance

General comments

Acronyms for health-care acquired conditions and related terms used in the proposed rule need to have clearer definitions that are consistent across the federal government and healthcare industry.

AHIMA is referring to the following sample of terms:

HAC – Hospital-acquired condition

HCAC – Health care-acquired condition

OPPC – Other provider-preventable condition

PPC – Provider-preventable condition

The distinctions among these terms in the proposed rule are confusing. For example, on page 76FR9288, CMS states that other provider-preventable conditions (OPPCs) would be applicable to other conditions that States identify and have approved through their Medicaid State plans. However, on page 76FR9290, CMS proposes to define OPPC to include, at a minimum, wrong surgical or other invasive procedure performed on a patient; a surgical or other invasive procedure performed on the wrong body part; and a surgical or other invasive procedure performed on the wrong patient. The inclusion of CMS-identified conditions does not fit with a definition of State-identified conditions. On page 76FR9294, there is another definition of OPPC – “a condition that could have reasonably been prevented through the application of evidence-based guidelines.” This definition would seem to not just be limited to OPPCs, but would reasonably apply to all of the categories of conditions described by the acronyms noted above. Furthermore, the terms are not used consistently even with the regulation itself. For example, it seems as though “HCAC” is sometimes used when “PPC” might be the more appropriate term.

I. Background (76FR9284)

CMS proposes to implement Medicaid health care-acquired conditions (HCAC) regulations that would provide some consistency across Medicare and Medicaid. AHIMA commends efforts to achieve greater standardization in identification and reporting of HCACs, as this will not only result in improved data comparability but also will reduce providers’ administrative burden when trying to comply with variable payer requirements. However, the proposal to accommodate State flexibility to design individual HCAC policies for nonpayment, quality-related programs limits this standardization. We recommend that the process of identifying and reporting provider-preventable conditions (PPCs) should be consistent with Medicare’s process to ensure data comparability across Medicaid programs and to reduce providers’ administrative burden. CMS indicates on page 9288 that one of the goals is to not cause undue burden on States or providers. However, whenever there is variability in reporting requirements across payers, it creates additional administrative burdens for providers.

AHIMA agrees with the proposal on page 76FR9289 that every State must, at a minimum, identify as a HCAC, those secondary diagnosis codes that have been identified as Medicare hospital-acquired conditions (HACs) when not present on hospital admission, and that the States are required to comply with subsequent updates or revisions to the Medicare HACs.

II. Provisions of the Proposed Regulation (76FR9289)

On page 76FR9289, CMS proposes that the term “code” would refer to ICD-9-CM or ICD-10-CM codes, or a “State-specified alternative method of identifying conditions for purposes of payment.” AHIMA strongly recommends that the ICD-9-CM and ICD-10-CM codes be consistently adopted and used as the only diagnoses standard for identifying conditions for purposes of Medicaid payment. It would be administratively burdensome for providers, as well as result in lack of data comparability across Medicare and Medicaid programs, to allow Medicaid programs to use alternative coding systems or their own method for identifying each PPC.

On page 76FR9290, CMS indicates they are soliciting comments on the efficiency of present on admission (POA) indicators for purposes of the provisions of this rule, given that the Office of Inspector General (OIG) has found that other methods may be more effective in detecting HACs. While we support the federal government’s efforts to research the most effective method for detecting HACs or HCACs, we believe that States must identify a HCAC through the same method as Medicare identifies a HAC to ensure uniformity. If and when Medicare considers changing its methodology, we strongly encourage CMS to modify the approach for Medicaid to align with Medicare’s to reduce administrative burden of identifying and reporting HACs and HCACs.

On page 76FR9290, the third criteria for States to use in identifying additional OPPCs states “A condition or event identified must be reasonably preventable, meaning an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.” AHIMA recommends that national clinical consensus should be a component of the criterion as to whether a condition is “reasonably preventable.”