



1730 M Street, NW, Suite 502  
Washington, DC 20036

phone » (202) 659-9440  
fax » (202) 659-9422  
web » www.ahima.org

June 17, 2011

Donald Berwick, MD  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: **CMS-1518-P**  
PO Box 8011  
Baltimore, Maryland 21244-1850

Dear Dr. Berwick:

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 (IPPS) and fiscal year 2012 Rates, as published as a notice of proposed rulemaking (NPRM) in the May 5, 2011 *Federal Register* (CMS-1518-P).

AHIMA is a professional association representing more than 61,000 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 standard for ethical coding. This response to the May 5 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 correct coding rules associated with 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

**Donald Berwick**  
**AHIMA Comment on 2012 IP-PPS**  
**Page 2**

measurement and in the development, planning, implementation and management of electronic health records.

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

**II. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights (76FR25797)**

**II-D – Proposed FY 2012 MS-DRG Documentation and Coding Adjustment, Including the Applicability to the Hospital-Specific Rates and the Puerto Rico-Specific Standardized Amount (76FR25801)**

**AHIMA urges CMS to stop referring to their proposed payment adjustment as a “documentation and coding” adjustment and instead refer to it as a “budget neutrality” adjustment or similar term as accurate coding is not the reason CMS is making such an adjustment.**

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, which are developed under HHS authority.

As CMS has acknowledged in various regulations, including past PPS rules and the ICD-10 rule, there is a growing demand for more accurate and detailed data due to new and expanding healthcare initiatives such as value-based purchasing, present on admission (POA) reporting, quality reporting, and patient safety monitoring.

A negative payment adjustment for improved coding and documentation is at odds with industry efforts to improve the quality of healthcare data, as well as with CMS’ own efforts to encourage hospitals to improve their coding specificity. It is also inconsistent with national goals to improve quality of care.

**Donald Berwick**

**AHIMA Comment on 2012 IP-PPS**

**Page 3**

Negative terminology used in regards to this adjustment also negatively portrays coding professionals' and clinicians' hard work and dedicated efforts toward improving the quality of documentation and coding— by directly associating these improvements with reduced payments to hospitals. AHIMA recognizes the requirement to maintain budget neutrality and the associated payment cuts that may need to occur. We also recognize that no payment cut for “coding and documentation improvements” would need to be made in the absence of a budget neutrality requirement. **Therefore, this payment adjustment should more appropriately be referred to as a “budget neutrality adjustment.”** We believe this change in terminology here and in other HHS and CMS statements and documents would more accurately reflect the true basis for the payment adjustment and eliminate the current widespread misperception that this adjustment is a penalty for accurate coding and documentation improvements.

**II-F-2a – Proposed Additions and Revisions to the HAC Policy for FY 2012:  
Contrast-Induced Acute Kidney Injury (76FR25813)**

AHIMA does not believe the proposed method of identifying contrast-induced acute kidney injury for purposes of applying the HAC payment provision will accurately and consistently identify this condition. Reporting of ICD-9-CM procedure codes in categories 87 and 88 is not currently required, and therefore, many hospitals do not typically report codes in these categories. Even when procedure codes in categories 87 and 88 are reported, the presence of one of these codes with code 584.9 does not indicate a link between the procedure and the renal condition.

ICD-9-CM diagnosis code 584.9, Acute kidney failure, unspecified, is not specific for acute kidney injury. Also, as noted in the FY 2011 IPPS final rule and the summary of the March 2011 ICD-9-CM Coordination and Maintenance Committee meeting, physicians often use variable terminology to describe acute renal failure, acute kidney injury, and associated renal conditions. As a result, not all contrast-induced acute kidney injuries may be reported with code 584.9, depending on the way in which the condition is documented by the physician.

So, even in those hospitals that report the procedure codes being proposed for identification of contrast-induced acute kidney injury, the combination of one of these codes with diagnosis code 584.9 does not unequivocally establish that the patient has this condition. Without a unique code for contrast-induced acute kidney injury, we do not believe this condition can be accurately and consistently identified, and therefore, **we oppose the addition of contrast-induced acute kidney injury to the HAC policy.** Since the US is heading into a partial code set freeze in preparation for ICD-10-CM/PCS implementation, **AHIMA recommends that consideration of adding contrast-induced acute kidney injury to the HAC policy be delayed until after ICD-10-CM/PCS**

**Donald Berwick**  
**AHIMA Comment on 2012 IP-PPS**  
**Page 4**

**implementation and a unique ICD-10-CM diagnosis code has been created for this condition.**

**II-F-2b – Proposed Additions and Revisions to the HAC Policy for FY 2012: New Diagnosis Codes Proposed to be Added to Existing HACs (76FR25814)**

We support the proposed addition of five new ICD-9-CM diagnosis codes to the Falls and Trauma HAC category, Surgical Site Infection Following Certain Bariatric Procedures HAC category, and Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures HAC category.

**II-F-2c – Proposed Additions and Revisions to the HAC Policy for FY 2012: Revision to HAC Subcategory Title (76FR25814)**

AHIMA supports the revision of the title of the “Electric Shock” HAC subcategory to “Other Injuries” because it includes a variety of injury codes.

**II-G-1a – Proposed Changes to Specific MS-DRG Classifications: Noninvasive Mechanical Ventilation (76FR25816)**

While AHIMA does not have a position as to whether a new MS-DRG should be created for patients receiving noninvasive mechanical ventilation, the data CMS relied on for its analysis may be incomplete. Our members have indicated that code 93.90, Noninvasive mechanical ventilation, is not consistently reported across all hospitals since it is not currently required for reporting purposes.

**II-G-1b – Proposed Changes to Specific MS-DRG Classifications: Debridement with Mechanical Ventilation Greater Than 96 Hours With Major Operating Room (O.R.) Procedure (76FR25819)**

We support CMS’ proposal not to create a new MS-DRG for mechanical ventilation greater than 96 hours with the presence of a major operating room procedure.

**II-G-1c – Proposed Changes to Specific MS-DRG Classifications: Autologous Bone Marrow Transplant (76FR25819)**

We support CMS’ proposed replacement of MS-DRG 015 with two new MS-DRGs that differentiate autologous bone marrow transplants with and without MCC/CC.

**Donald Berwick**  
**AHIMA Comment on 2012 IP-PPS**  
**Page 5**

**II-G-2 – Proposed Changes to Specific MS-DRG Classifications: Rechargeable Dual Array Deep Brain Stimulation System** (76FR25820)

AHIMA supports the proposed assignment of rechargeable dual array systems for deep brain stimulation to MS-DRGs 023 (Craniotomy with Major Device Implant/Acute Complex CNS PDX with MCC or Chemo Implant) and 024 (Craniotomy with Major Device Implant/Acute Complex CNS PDX without MCC).

**II-G-3 – Proposed Changes to Specific MS-DRG Classifications: Skull Based Surgeries** (76FR25821)

We support CMS' proposal not to reclassify skull-based surgical procedures.

**II-G-4a – Proposed Changes to Specific MS-DRG Classifications: Percutaneous Mitral Valve Repair with Implant** (76FR25822)

While we support CMS' proposal not to make any MS-DRG changes for procedure code 35.97, Percutaneous mitral valve repair with implant for FY 2012, **AHIMA recommends re-evaluating the MS-DRG assignment next year when more claims data for this code is available.**

**II-G-4b – Proposed Changes to Specific MS-DRG Classifications: Aneurysm Repair Procedure Codes** (76FR25822)

AHIMA supports the proposed movement of procedure codes 38.45, Resection of vessel with replacement, thoracic vessel, and 39.73, Endovascular implantation of graft in thoracic aorta, from MS-DRGs 237 (Major Cardiovascular Procedures with MCC or Thoracic Aortic Aneurysm Repair) and 238 (Major Cardiovascular Procedures without MCC) to MS-DRGs for cardiac valve and other major cardiothoracic procedures (MS-DRGs 216, 217, 218, 219, 220, and 221). We also support the corresponding modification to MS-DRG 237 to delete "or Thoracic Aortic Aneurysm Repair" from the title.

**II-G-5a – Proposed Changes to Specific MS-DRG Classifications: Artificial Discs** (76FR25826)

We support CMS' proposal not to create a new MS-DRG for artificial disc procedures or reassign code 84.62, Insertion of total spinal disc prosthesis, cervical, to MS-DRGs 471 through 473 and code 84.65, Insertion of total spinal disc prosthesis, lumbosacral, to MS-DRGs 459 and 460.

**Donald Berwick**  
**AHIMA Comment on 2012 IP-PPS**  
**Page 6**

**II-G-5b – Proposed Changes to Specific MS-DRG Classifications: Major Joint Replacement or Reattachment of Lower Extremities (76FR25827)**

We support retaining the existing severity levels for MS-DRGs 469 (Major Joint Replacement or Reattachment of Lower Extremity with MCC) and 470 (Major Joint Replacement or Reattachment of Lower Extremity without MCC).

**II-G-5c – Proposed Changes to Specific MS-DRG Classifications: Combined Anterior/Posterior Spinal Fusion (76FR25827)**

We support the proposal not to reassign procedure code 81.08, Lumbar and lumbosacral fusion of the anterior column, anterior technique, to MS-DRGs 453 through 455 (Combined Anterior/Posterior Spinal Fusion with MCC, with CC, and without CC/MCC).

**II-G-6 – Proposed Changes to Specific MS-DRG Classifications: Excisional Debridement of Wound, Infection, or Burn (76FR25830)**

AHIMA supports CMS' proposal to remove procedure code 86.22, Excisional debridement of wound, infection, or burn, from their MS-DRG assignments within MS-DRGs 573 through 578 for skin grafts and assign them to new excisional debridement MS-DRGs.

**II-G-7a– Proposed Changes to Specific MS-DRG Classifications: Nutritional and Metabolic Diseases (76FR25833)**

We support the proposed revision of the titles for MS-DRGs 640, 641, and 642 to better reflect the cases assigned to these MS-DRGs.

**II-G-7b– Proposed Changes to Specific MS-DRG Classifications: Sleeve Gastrectomy for Morbid Obesity (76FR25833)**

We support adding procedure codes for sleeve gastrectomy to MS-DRGs 619 through 621 (O.R. Procedures for Obesity with MCC, with CC, and without CC/MCC, respectively).

**II-G-8– Proposed Changes to Specific MS-DRG Classifications: Discharge Status Code 66 (Discharged/Transferred to Critical Access Hospital) (76FR25833)**

We support the proposed addition of discharge status code 66, Discharged/Transferred to Critical Access Hospital (CAH), to the MS-DRG Grouper logic for MS-DRG 789 (Neonate, Died or Transferred to Another Acute Care Facility).

**Donald Berwick**  
**AHIMA Comment on 2012 IP-PPS**  
**Page 7**

**II-G-10– Proposed Changes to Specific MS-DRG Classifications: Surgical Hierarchies** (76FR25834)

AHIMA supports the proposed revision of the surgical hierarchies for pre-MDCs and MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue, and Breast).

**II-G-11b-(1)-a– Proposed Changes to Specific MS-DRG Classifications: Complications or Comorbidity Exclusions List – Pressure Ulcer Diagnosis Codes** (76FR25836)

We support the removal of diagnosis codes 707.23, Pressure ulcer, stage III, and 707.24, Pressure ulcer, stage IV, from the CC Exclusion List when a principal diagnosis code of one of codes 707.00 through 707.09 (Pressure ulcer) is reported.

**II-G-11b-(1)-b– Proposed Changes to Specific MS-DRG Classifications: Complications or Comorbidity Exclusions List – End-Stage Renal Disease Diagnosis Code** (76FR25836)

We support CMS' proposal to add diagnosis code 585.6, End-stage renal disease, to the CC Exclusion List when reported with a principal diagnosis code of 403.90, Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified. It would represent incorrect coding to report codes 403.90 and 585.6 together. Code 585.6 should only be reported with code 403.91, Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end-stage renal disease.

We agree with CMS' proposal not to add diagnosis code 585.6 to the CC Exclusion List when reported with a principal diagnosis of code 403.91.

**II-G-11b-(1)-c– Proposed Changes to Specific MS-DRG Classifications: Complications or Comorbidity Exclusions List – Hypertensive Chronic Kidney Disease with Chronic Kidney Disease Stage V or End-Stage Renal Disease Code** (76FR25836)

AHIMA supports the proposed addition of diagnosis code 403.91, Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end-stage renal disease, to the CC Exclusion List when reported as a secondary diagnosis code with principal diagnosis code 585.6, End-stage renal disease.

**Donald Berwick**  
**AHIMA Comment on 2012 IP-PPS**  
**Page 8**

**II-G-11b-(2) – Proposed Changes to Specific MS-DRG Classifications: Complications or Comorbidity Exclusions List – Suggested Changes to Severity Levels for Encephalopathy** (76FR25836)

We support CMS' proposal to retain the encephalopathy codes on the MCC list and not change them to CCs.

**II-G-11b-(3) – Proposed Changes to Specific MS-DRG Classifications: Complications or Comorbidity Exclusions List – Suggested Changes to Severity Levels for Mechanical Complication and Infection Due to Device Related Codes** (76FR25837)

We support the proposed retention of codes 996.01, Mechanical complication of cardiac device, implant, and graft due to cardiac pacemaker (electrode), 996.04, Mechanical complication of cardiac device, implant, and graft due to automatic implantable cardiac defibrillator, and 996.61, Infection and inflammatory reaction due to internal prosthetic device, implant, and graft due to cardiac device, implant, and graft, on the CC list.

**II-G-14a-(1) – Proposed Changes to Specific MS-DRG Classifications: Other Issues– Brachytherapy Code** (76FR25844)

We support the proposal not to make any MS-DRG changes for procedure code 92.27, Implantation or insertion of radioactive elements.

**II-G-14a-(2) – Proposed Changes to Specific MS-DRG Classifications: Other Issues– Intraoperative Electron Radiation Therapy (IOERT)** (76FR25844)

We support CMS' proposal not to change the MS-DRG assignment for intraoperative electron radiation therapy (IOERT) cases.

**II-G-14b – Proposed Changes to Specific MS-DRG Classifications: Other Issues– IPPS Recalled Device Policy Clarification** (76FR25849)

AHIMA agrees with CMS' proposal to make the IPPS policy for recalled devices consistent with the Outpatient Prospective Payment System policy.

**Donald Berwick**  
**AHIMA Comment on 2012 IP-PPS**  
**Page 9**

## **IV. Other Proposed Decisions and Changes to the IPPS for Operating Costs and GME Costs (76FR25890)**

### **IV-A-1 – Hospital Inpatient Quality Reporting (IQR) Program: Background** (76FR25890)

Because the transition to ICD-10-CM/PCS is rapidly approaching and will impact the quality measurement reporting program, we urge CMS to provide an overview of the plans for transitioning the measures to reflect the code changes. We believe providing the industry with additional information is essential in order to assist with transition planning and preparation.

AHIMA is pleased to see in the proposed rule CMS' explicit intent to align the clinical quality measure requirements of the Hospital Inpatient Quality Reporting (IQR) Program with various other programs in order to prevent reporting requirements from becoming over burdensome to the health care community.

AHIMA supports the principles for the development and use of measures and scoring methodologies as outlined in the proposed rule.

We encourage CMS to provide additional clarification regarding the consideration of a range of consensus endorsement entities that assist with the measure development process.

### **IV-A-2 – Hospital Inpatient Quality Reporting (IQR) Program: Retirement of Hospital IQR Program Measures** (76FR25892)

In general, AHIMA supports CMS' criteria that will be considered when determining whether to retire measures.

### **IV-A-3 – Hospital Inpatient Quality Reporting (IQR) Program: Proposed Measures for the FY 2014 and FY 2015 Hospital IQR Payment Determinations** (76FR25892)

Regarding the proposal to have hospitals "solely" switch to EHR reporting by 2015, AHIMA believes this date is premature. **AHIMA does not support the notion all hospitals will have this capability and encourage CMS to reconsider this date.**

Regarding the proposed Medicare Spending per Beneficiary Measure, we are concerned that a consensus and endorsement process doesn't appear to have been used for development of this measure. Also, the intent of including this measure in a quality

**Donald Berwick**  
**AHIMA Comment on 2012 IP-PPS**  
**Page 10**

reporting program is not clear, as this measure doesn't evaluate the quality of care provided.

AHIMA questions the value of collecting the measure for "Participation in a Systematic Clinical Database Registry for General Surgery." Not all hospitals participate in this registry and if they will be required to report from this registry, it will create an additional cost to the organization.

We are concerned that CMS is selecting measures that have not been endorsed by the National Quality Forum (NQF) or another consensus entity. CMS has historically promoted the process of selecting measures that have undergone a rigorous consensus review process to ensure the measures are vetted appropriately.

Since the Stroke and VTE measures are part of the Meaningful Use program, **AHIMA recommends that they be delayed until 2015**, in order to avoid implementing a burdensome chart abstraction process and then switching to reporting under Meaningful Use two years later.

**IV-A-4 – Hospital Inpatient Quality Reporting (IQR) Program: Possible New Quality Measures and Measure Topics for Future Years** (76FR25911)

While AHIMA supports CMS' goal of reducing the administrative burden of chart abstraction through the use of EHR-based reporting, we believe the target date of 2015 is unrealistic. Many hospitals' health records will not be completely electronic yet. If CMS wishes to limit the number of chart-abstracted measures in order to facilitate the transition to EHR-based reporting, we urge CMS to adopt our recommendation outlined above to delay the Stroke and VTE measures until they are required as part of the Meaningful Use program.

**IV-A-5 – Hospital Inpatient Quality Reporting (IQR) Program: Form Manner, and Timing of Quality Data Submission** (76FR25914)

Regarding the Hospital IQR procedural requirements, AHIMA recommends that the timeframes be re-evaluated and efforts be made to synchronize them with other standard reporting requirements, such as the Joint Commission's requirements and timeframes.

AHIMA is concerned that the two healthcare-associated infection (HAI) measures being proposed have not been endorsed by a consensus entity. Also, for hospitals that don't currently use the NHSN, transition to this reporting process will be burdensome and will require the implementation of a new infrastructure.

**Donald Berwick**  
**AHIMA Comment on 2012 IP-PPS**  
**Page 11**

**IV-A-6 – Hospital Inpatient Quality Reporting (IQR) Program: Proposed Chart Validation Requirements for Chart-Abstracted Measures** (76FR25920)

AHIMA opposes the proposed change from 45 days to 30 days for medical record submission for chart validation purposes, as this decrease in the timeframe would severely impact hospitals' capability to respond in a timely manner.

**IV-A-7 – Hospital Inpatient Quality Reporting (IQR) Program: Proposed QIO Regulation Changes for Provider Medical Record Deadlines Possibly Including Serious Reportable Events** (76FR25922)

CMS proposes to require the submission of medical information within 21 days in those situations in which a "serious reportable event" or other circumstance has been identified during the course of a Quality Improvement Organization (QIO) review. Clarification is needed as to the definition of "medical information." Does this refer to the complete medical record, or rather, portions of the medical record? What if the medical record is not yet complete?

**IV-A-12 – Hospital Inpatient Quality Reporting (IQR) Program: Electronic Health Records (EHRs)** (76FR25925)

AHIMA believes that 2015 is too early for CMS to no longer accept chart-abstracted data for the Hospital IQR Program. Not all hospitals will have fully implemented EHRs at that time.

We have concerns about the option that would allow hospitals to submit the same measure for the Hospital IQR Program based on either chart abstraction or EHR-based reporting. This would require significant testing to ensure validity and consistency between the two methods.

**IV-P-2 – Proposed Changes to MS-DRGs Subject to the Postacute Care Transfer Policy: Proposed Changes to the Postacute Care Transfer MS-DRGs** (76FR25962)

AHIMA supports the proposed changes to the MS-DRGs subject to the postacute care transfer policy.

## **VII. Proposed Changes to the Long-Term Care Hospital Prospective Payment System (LTCH PPS) for FY 2012 (76FR25971)**

### **VII-C-2 – Proposed Quality Reporting for LTCHs: Proposed Quality Measures for the LTCH Quality Reporting Program for FY 2014 (76FR25982)**

AHIMA is concerned that the proposed quality measures for long-term care hospitals (LTCHs) were developed for specific populations (i.e., intensive care units, high-risk nursery) in the acute-care hospital setting and for short-stay nursing home patients, and have not been evaluated for applicability and validity in the LTCH setting. CMS states in the proposed rule that these measures are “highly relevant” to the LTCH setting, but no data is provided to support this statement. It appears as though the statement as to relevance may be based on the subject of the measure (e.g., use of central line catheters in the LTCH setting) rather than the actual measures themselves.

### **VII-C-4 – Proposed Quality Reporting for LTCHs: Proposed Data Submission Methods and Timelines (76FR25988)**

As with acute-care hospitals, we are concerned about the administrative burden of using NHSN for quality data submission for those LTCHs that have not previously submitted data via this mechanism.

## **Conclusion**

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare Hospital IPPS program for FY 2012. 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 me at (312) 233-1115 or [sue.bowman@ahima.org](mailto:sue.bowman@ahima.org). In my 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](mailto:dan.rode@ahima.org), or AHIMA’s director for federal affairs, Allison Viola, at (202) 659-9440 or [allison.viola@ahima.org](mailto:allison.viola@ahima.org).

Sincerely,



Sue Bowman, RHIA, CCS  
Director, Coding Policy and Compliance

cc: Dan Rode, MBA, CHPS, FHFMA  
Allison Viola, MBA, RHIA