American Health Information Management Association®

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Mark McClellan, MD, PhD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1488-P**
PO Box 8011
Baltimore, Maryland 21244-1850

Dear Dr. McClellan:

The purpose of this letter is to comment on the Centers for Medicare & Medicaid Services' (CMS') proposed changes to the Medicare Hospital Inpatient Prospective Payment Systems (IP-PPS) and fiscal year 2007 Rates, as published in the April 25, 2006 *Federal Register* (CMS-1488-P). The American Health Information Management Association (AHIMA) supports the goal of refining the DRG system to better account for severity of illness and as part of a roadmap for improving healthcare data. However, as we explain in detail below, we believe implementation of a new severity-adjusted DRG system should be delayed until after other steps have been taken to improve the quality of healthcare data used as the foundation for this system.

AHIMA is a professional association representing more than 50,000 health information management (HIM) professionals who work throughout the healthcare industry and whose work is closely engaged with the diagnoses and procedure classification systems that serve to create the diagnoses related groups discussed in this proposed rule. As part of our effort to promote consistent coding practices, AHIMA is 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 *International Classification of Diseases Ninth Revision, Clinical Modification* (ICD-9-CM).

Our recognition of the industry's need for consistency in medical coding, improved data integrity, and more precise and contemporary data that reflects 21st century medicine has led AHIMA and others to advocate for adoption and coordinated implementation of ICD-10-CM and ICD-10-PCS for the past several years. It is clear in reviewing this proposal that CMS should have, likewise, continued to advocate for this same conversion. Without the detailed and expanded data these contemporary classifications systems can provide it appears the proposed Medicare severity-based DRG system is premature and will create significant data and payment problems for both the Medicare program and the healthcare providers who serve the Medicare beneficiaries.

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# II-B: DRG Reclassifications

Unless otherwise noted, AHIMA supports CMS' proposed DRG modifications.

**II-B-3 - DRGs: Severity of Illness** (71FR24011)

AHIMA supports CMS' goal of refining the Medicare DRG system to better account for severity of illness. However, **after analysis of the proposed rule, and input from HIM professionals who have used the APR-DRG system, it is our conclusion that APR-DRGs should not be implemented in FY 2007 or 2008.** While AHIMA recognizes that CMS is under a Congressional mandate to implement a refinement of the DRG system by FY 2007, our concerns are as follows:

- The proposed implementation timeline for the new DRG system fails to take into account the adoption of ICD-10-CM and ICD-10-PCS, even though CMS has been actively involved in the development of these systems: Continued use of an obsolete and increasingly ambiguous classification system such as ICD-9-CM limits, and to a certain extent could negate, some of the anticipated benefits of a severity-adjusted DRG system. The greater clinical detail in ICD-10-CM may result in different consolidated severity-adjusted DRG assignments due to a greater differentiation in severity of illness than is possible with ICD-9-CM. Also, since implementation of ICD-10-CM and ICD-10-PCS is anticipated in the next few years, it would be administratively burdensome to implement a new DRG system now and then have to implement modifications to accommodate ICD-10-CM and ICD-10-PCS in a few years. The experience both CMS and hospitals will have gained from using an ICD-9-CM based severity-adjusted DRG system may not be entirely relevant under an ICD-10-CM/PCS based system.

- The consolidated severity-adjusted DRG system, as proposed, is too complex for a two-month implementation and long-term use: The complexity of the APR-DRG system makes it very difficult to analyze case mix changes or evaluate accuracy of DRG assignment, due to the complicated interaction of multiple diagnoses and other factors. Coding professionals are often called upon to audit the coding of an episode of care to determine coding accuracy. Coding professionals with APR-DRG audit experience have indicated that the complexity of this system makes it difficult to determine the reason(s) for similar cases being classified differently and to identify errors. **The richer clinical detail captured by a more detailed classification system, such as ICD-10-CM and ICD-10-PCS, might facilitate the design of a severity-adjusted DRG system with less complex decision logic. A simpler severity-adjusted DRG system that is based on a more modern classification system has the potential for increased coder productivity, improved ability to detect and prevent errors and fraud, and more widespread use of computer-assisted technology**

- The proposed severity-adjusted DRG system needs to account for a complete picture of the diagnoses and procedures involved: In order for appropriate severity-adjusted DRG assignment to occur, it is imperative that all reported diagnosis and procedure codes be included in the DRG calculation. Medicare does not process more than nine diagnoses and six procedures, CMS' analysis of the impact of APR-DRGs and the development of the consolidated severity-adjusted DRG system did not include all reported diagnoses and procedures, which means that this process relied on incomplete data. AHIMA has recommended in previous comment letters on annual IPPS revisions that CMS process all reported diagnoses and procedures. The severity of illness of hospital inpatients has increased over the last decade, due to shifts in the provision of care from the inpatient to outpatient setting. This has

led to an increase in the number of comorbidities per hospital admission. Demands for greater coding specificity have also led to an increase in the number of reported diagnosis and procedure codes. Given this situation, AHIMA recommends that hospitals report all codes that are reportable according to the *ICD-9-CM Official Guidelines for Coding and Reporting* and that CMS accept and use all submitted codes in the DRG calculation**.** Since the proposed DRG system determines severity of illness based on the interaction of multiple diseases, as well as on procedures performed and other factors, it is very possible that diagnoses below the ninth diagnosis field and procedures below the sixth procedure field on the claim could impact the final severity-adjusted DRG assignment. **Until CMS has a full picture of the severity and services received by its Medicare patients, any system will result in inaccurate data and resulting decisions.**

- Circumstances that impact resource utilization are not fully accounted for in the proposed APR-DRG system: AHIMA agrees with the statement in the Proposed Rule that modifications to the consolidated severity-adjusted DRG system need to be made in order to account for increased complexity that is unrelated to severity of illness, such as the use of certain technologies. However, in **addition to the use of medical technologies, there are other circumstances that impact resource utilization that are not currently accounted for in the APR-DRG system and need to be addressed in the new severity-adjusted DRG system, such as the performance of bilateral procedures.**

  As CMS considers modifications to the consolidated severity-adjusted DRG system to capture increased complexity related to the use of technologies and other distinctions in the performance of procedures, it is important to keep in mind that ICD-9-CM procedure codes are increasingly limited in their ability to capture distinctions in medical procedures, including the use of medical technologies. The structure of ICD-9-CM is insufficiently flexible to continue to accommodate revisions needed to identify the use of new medical technology. In order to appropriately capture increased complexity related to the use of certain technologies, it is essential that these technologies be adequately identified by our procedure coding system. **The CMS designed and maintained ICD-10-PCS must be implemented as a replacement for the ICD-9-CM procedure coding system in order for a severity-adjusted DRG system to effectively reflect the complexity of the care provided.**

- Implementation of the proposed APR-DRG system could result in violations of official coding guidelines mandated under HIPAA**:** We are aware of instances in the APR-DRG system where code sequencing and combinations violate the *ICD-9-CM Official Guidelines for Coding and Reporting.* In some cases, diagnoses are automatically resequenced for APR-DRG assignment due to inappropriate assumptions about the relationship between two diagnoses. For example, if a patient has a final diagnosis of non-cardiac chest pain and a history of coronary artery disease, the case is automatically assigned to a coronary artery disease APR-DRG, even though the documentation indicates the chest pain is not related to the coronary artery disease. In other cases, code combinations that should not be reported according to the *ICD-9-CM Official Guidelines for Coding and Reporting* (such as conditions integral to an established diagnosis) impact the final APR-DRG assignment.

  We believe that any Medicare DRG system should conform to the official coding guidelines and that CMS should make necessary modifications to ensure that that the system logic supports proper coding practices. **We recommend that CMS work with the other Cooperating Parties (American Health Information Management Association, American Hospital Association, National Center for Health Statistics) to make modifications to the severity-adjusted DRGs to ensure consistency**

**with official coding rules and guidelines. We also suggest as we have above that a less-complex system using contemporary classification codes would better ensure a system that can continue to adhere to the *Official Guidelines for Coding and Reporting*.**

- The Proposed Rule does not address concerns for ongoing public input into the DRG process or the methodology and logic contained in the system: Given the proprietary nature of the APR-DRG system, it remains unclear just how and when changes in the system will occur and how the industry will be involved in this system in the future. **We believe that the methodology and logic of any Medicare DRG system should be in the public domain and the revision process should allow for educated public input.**

- The Proposed Rule does not address the impact on other Medicare policies**:** The impact on other Medicare policies, such as the post-acute transfer policy, needs to be addressed well before any implementation. Currently, 182 DRGs are subject to the post-acute transfer policy. Since there is no crosswalk between the current DRGs and the APR-DRGs, **CMS will need to determine how cases subject to this policy, and similar policies, will be identified.**

- The Proposed Rule does not address the impact on other PPS systems: The impact on other Medicare PPS systems that use the hospital inpatient DRGs also needs to be addressed. For instance, will other PPS systems, such as long-term acute care hospitals and psychiatric facilities, continue to use the existing DRGs, or will they also transition to the consolidated severity-adjusted DRGs?

In response to your comment on partial implementation, it is obvious that AHIMA agrees with CMS that there are many practical difficulties associated with partial implementation of the consolidated severity-adjusted DRGs in FY 2007 and complete implementation in FY 2008.

**While AHIMA believes implementation of a severity-adjusted DRG system should be delayed, we support making changes to the current DRG system to better account for severity of illness (such as the changes made in FY2006 to the cardiac DRGs).** Once ICD-10-CM and ICD-10-PCS have been implemented, then adoption of a severity-adjusted DRG system can occur. In the meantime, further analysis can be done to identify the best system, or modification thereof, for improving the effectiveness of the IP-PPS.

**II-C-3c – Changes to Case Mix Index (CMI) from a New DRG System** (71FR24019)

The proposed rule notes a concern about the potential for more accurate and complete documentation and coding under the consolidated severity-adjusted DRG system, since coding that has no effect on payment under the current DRG system may result in a case being assigned to a higher paid DRG under the new system. However, hospitals and other healthcare providers are required to adhere to the *ICD-9-CM Official Guidelines for Coding and Reporting*, which provide direction for reporting diagnoses and procedures without regard to the reimbursement impact. Therefore, some of the conditions and procedures that are already being coded and reported, and have no current impact on reimbursement, may impact the consolidated severity-adjusted DRG assignment. Additionally, in some cases, these conditions and procedures may be reported below the ninth diagnosis and sixth procedure field and therefore have not been processed by Medicare under the current system. It is crucial that classification codes be assigned as dictated under the Official Guidelines for reasons beyond the reimbursement for services. And as we

stated earlier, it is also essential that all reported diagnoses and procedures be processed by Medicare in order for the appropriate severity-adjusted DRG to be calculated. **We recommend that Medicare begin to process all reported diagnoses and procedures as soon as possible.**

# II-D: Proposed Changes to Specific DRG Classifications

**II-D-5 – Severe Sepsis** (71FR24037)

As noted during previous discussions with CMS staff, we believe that one of the major problems hospitals are experiencing with the classification of sepsis in the DRG system is that patients with a principal diagnosis of sepsis on mechanical ventilation are not classified to a DRG that accounts for the use of mechanical ventilation. Under the ICD-9-CM rules and guidelines, a patient admitted with sepsis who develops respiratory failure as a result of the sepsis will have a principal diagnosis of sepsis, which means the admission will not be classified to DRG 475. We believe there are other principal diagnoses where this situation occurs – when a non-respiratory condition is reported as the principal diagnosis and the patient is on mechanical ventilation.

**We continue to urge CMS to consider modifying the current DRG system such that admissions involving mechanical ventilation are classified to different DRGs than those that do not involve mechanical ventilation, including instances when the principal diagnosis is a non-respiratory condition. We also urge CMS to consider mechanical ventilation as modifications are made to the severity-adjusted DRGs to account for increased complexity due to the use of technologies.**

**Table 6E- Revised Diagnosis Codes** (71FR24292)

In Table 6E, revised diagnosis codes 403.10, 403.90, 404.10, and 404.90 show a CC status of "N." The fifth digits for these codes have been revised to split the chronic kidney disease component between stages I through IV (and unspecified) and stage V or end stage renal disease. The codes with fifth digits indicating chronic kidney disease of stages I through IV (or unspecified) are being proposed as non-CCs for FY2007. It is not clear what data are being used to support this change. Currently, all of the codes in category 585, chronic kidney disease, are considered CCs, including the codes for stages I through IV and unspecified. We believe the CC status of the codes in categories 403 and 404 should be consistent with the CC status of the codes in category 585.

Also, codes 403.00, 403.10, and 403.90 (hypertensive kidney disease with stages I through IV or unspecified chronic kidney disease) have been classified to DRGs 331, 332, and 333 (Other Kidney and Urinary Tract Diagnoses). This means that hypertensive kidney disease with stages I through IV (or unspecified) chronic kidney disease will no longer be classified to DRG 316 (Renal Failure). Currently, all chronic kidney disease codes are classified to DRG 316, regardless of the stage. Since no changes have been proposed for category 585, chronic kidney disease of any stage in a patient without hypertension will continue to be classified to DRG 316. But if the patient has hypertension, and stage I through IV (or unspecified) chronic kidney disease, the case will be classified to DRGs 331, 332, and 333. **We recommend that the DRG assignment for chronic kidney disease should be consistent for categories 403 and 585.**

# IV-A: Reporting of Hospital Quality Data for Annual Hospital Payment Update

**IV-A-3 – Electronic Medical Records** (71FR24095)

AHIMA welcomes CMS' ongoing support for adoption of certified electronic health records (EHRs) with their potential to significantly improve the quality, safety, and efficiency of healthcare.

The adoption of uniform standards for the EHR will permit the submission of standard reporting of secondary data, such as the quality monitoring data noted in section IV-A-3. Quality reporting should be a byproduct of a well designed EHR, and CMS must be clear that it is the EHR architecture that will convert the primary data of the EHR into the secondary data for reporting such as for quality monitoring data. It is inappropriate to suggest building monitoring measures into the EHR (primary data) itself – clinicians should not be forced to chart to these external measures that could change over time. National uniform standards for the EHR should be in place to ensure proper charting or documentation requirements will produce primary data that can be combined to produce the secondary data needed for quality monitoring, public health reporting, biosurveillance, reimbursement and so forth, as well as for development of internal point-of-care decision support.

AHIMA applauds the efforts that CMS has made to standardize its quality monitoring measures. However, we continue to be concerned that this effort for quality measurements is not uniform or standard across all third parties - governmental and private. The lack of an industry standard is a negative incentive to providers of such information, and to the vendors who must work with providers to attempt to produce the direct or automatic reporting suggested in section IV-A-3. While the proposed rule cites the Federal Health Architecture Data Standards, these standards have not been adopted as standards across the entire healthcare industry. Today, providers often find themselves having to meet competing measurement requirements that result in conflicting reports of an organization's quality of care. These conflicts make the entire process extremely expensive and frustrating, and create barriers to full clinician involvement and consumer trust.

**AHIMA suggests that once measurement standards can be adopted by the healthcare industry via the Health Information Technology Standards Panel (HITSP), criteria for the architecture needed to produce such measurements could then come from the Commission for the Certification of Health Information Technology (CCHIT) certification of EHRs. This would provide the end result that CMS is seeking.**

# IV-B: Value-Based Purchasing

As noted above uniform data content standards will be crucial in the effort to achieve value-based purchasing. A standard EHR will facilitate the process for automated data transmission, and EHR vendors will be more apt to incorporate measurement reporting capabilities into EHR products if measure specifications were standardized across the industry and various segments of provides. This would streamline the hospital data submission procedures and provide the ability for providers to view real-time measurement results to initiate their own improvement interventions in a timelier manner.

**IV-B-a –Measure Development and Refinement (71FR24097)**

AHIMA commends CMS for the steps it has taken to develop performance or quality measurements in a consensus process with stakeholders. As previously stated, only though the development and acceptance of uniform, consistent measurement standards can the US establish uniform data and provide incentives to providers currently faced with myriad requests for inconstant secondary data. As we have noted elsewhere in this letter, it is unfortunate that HHS has chosen not to move forward with the 2003 National Committee on Vital and Health Statistic recommendation that HHS adopt the ICD-9-CM upgrades (That is ICD-10-CM and ICD-10-PCS) developed by the CDC and CMS. Had the ICD-9-CM upgrades been moved through the adoption process, claims data would be available now that would significantly add to the knowledge needed to judge severity, quality, and other factors under consideration.

Likewise, we have mentioned above the need to consider requiring and accepting more than the current nine diagnosis and six procedure codes on the Medicare claims transmission. The Accredited Standards Committee X12's transactions standards – approved under HIPAA – can carry the full set of codes reflecting an episode of care, which in turn can give a fuller picture of the patient's health and care than the limited number of codes now used in the Medicare process and evaluations.

AHIMA remains concerned that even though there is an active program under way to develop standard measurements for quality, the lack of detailed diagnoses and procedure data, that could be available with the use of ICD-10-CM and ICD-10-PCS, will make the information gathered incomplete and inconsistent when it comes to using it for the measurement of quality and other factors.

**IV-B-4b – Data Infrastructure** (71FR24097)

As CMS considers the data infrastructure associated with its value-based purchasing system, it must keep in mind the transformation to a standard EHR that is currently underway. Expansion of the existing data submission and validation process used for the RHQDAPU program could be streamlined if data could be submitted directly from hospitals with the standard EHR system – this in turn would be an incentive for such facilities to adopt the standard EHR. CMS must also keep in mind and play a role in the development of a nationwide health information network (NHIN). It would be inappropriate to have a mechanism developed unilaterally for Medicare that could conceivably be incorporated into the NHIN at the same time as similar measures for other health plans creating duplicate but disparate systems. Similarly, CMS' QIO contractors should be involved in the local efforts underway in many communities for health information exchange to assure consistency and uniformity, as encouraged by HHS.

As long as hospital medical records reside in a paper-based format, or electronic formations that are inconsistent and don't allow for the necessary data capture and architecture to permit uniform reporting the validation process will remain labor intensive. In the interim between now and when a substantial number of hospitals are up on a standard EHR, the data submission and validation process could be improved if hospitals were only required to submit the portions of the medical records that are required for validation abstraction. This would reduce copying costs and other related costs as well as speed abstraction times for the Clinical Data Abstraction Center. A "validation waiver" process could also be considered. This process would allow those hospitals that achieve validation results at or above 90 percent for two consecutive quarters to receive a "validation waiver" for one or two validation quarters.

**IV-B-c – Incentive Methodology**

While the proposed rule seeks input on incentives for participation in value-based purchasing, we would simply reaffirm our comments that the structure and standards underway and under contemplation could do much to ensure the national adoption of EHR and NHIN standards, which in turn could, to some extent, lower the costs of procuring EHRs and providing the necessary data to CMS. Administrative costs are still far too high in the US health system. AHIMA agrees there is value in building a system and network that will allow us to identify quality, reduce medical injury, and promote population health. Whatever system CMS decides to build in the interest of value-based purchasing should also reflect these goals and not present barriers to them.

**IV-B-5 – Considerations Related to Certain Conditions, Including Hospital-Acquired Infections** (71FR24100)

In response to CMS' comments regarding the legislative requirement for hospitals to report the secondary diagnoses that are present on admission, effective October 1, 2007, we are interested in CMS' plans for how this information will be collected. Since the current version of the electronic claim (X12 version 4010) does not contain a field for collecting "present on admission" information, and the next version will not be implemented by October 2007, we are concerned about the potential for an administratively burdensome reporting process outside the claim submission process.

# Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare Hospital Inpatient PPS program for fiscal year 2007. AHIMA supports CMS' goal of refining and developing a severity-adjusted DRG system. However, many of the proposed rule's recommendations ignore the fact that providers currently use a 30-year old classification system and are prohibited from sending all of the data that could be used to develop a more accurate and comprehendible severity-adjusted DRG system that would achieve the goals laid out by Congress.

With this proposed rule, we face the prospect of a rapidly changed reimbursement system without having first improved the obsolete classification system on which it is based and the transaction standards necessary to carry such data. **If CMS and HHS fail to meet the need for 21st century classification systems and up-to-date transaction standards, we believe the goals set out by CMS, and required by Congress, to improve the DRG system and the collection and use of quality monitoring data will fail.**

AHIMA agrees that uniform adoption of a standard EHR will significantly improve clinical care and has the potential to provide good secondary data for a variety of purposes including quality. AHIMA is an active developer and promoter of the standard EHR and AHIMA and its 50,000 HIM professions want to see the standard EHR succeed. We want to see a day when secondary data, whether it is being produced for quality measurement, public health reporting, or reimbursement accurately portrays the diagnoses, severity, and services or procedures provided.

AHIMA stands ready to work with CMS and the healthcare industries to see that all these goals, including those of CMS for accurate payment, are met. 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, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

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Vice President, Policy and Government Relations

cc: Sue Bowman, RHIA, CCS