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November 8, 2022

Mady Hue  
Centers for Medicare and Medicaid Services  
CMM, HAPG, Division of Acute Care  
Mail Stop C4-08-06  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

Dear Ms. Hue:

The American Health Information Management Association (AHIMA) respectfully submits the following comments on the ICD-10-PCS code proposals presented at the September ICD-10 Coordination and Maintenance (C&M) Committee meeting and being considered for implementation on October 1, 2023.

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. The AHIMA mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and providers. Our leaders work at the intersection of healthcare, technology, and business, and are found in data integrity and information privacy job functions worldwide.

### **Implantation of Extraluminal Support Device During Arteriovenous Fistula Creation**

AHIMA does not support creation of a unique code to identify implantation of an extraluminal support device during arteriovenous fistula creation, since no new technology add-on payment (NTAP) application has been submitted and none is anticipated. We believe implantation of this device can be appropriately captured with existing codes in table 05U, as described under Current Coding in the topic packet.

### **Implantation of Ultrasound Penetrable Cranioplasty Plates**

We support Option 2, the creation of new table XNR Replacement of Bones, with a new device value D Synthetic Substitute, Ultrasound Penetrable applied to the body part value 8 Skull, to identify implantation of an ultrasound penetrable cranioplasty plate.

## **Insertion of Transcatheter Bicaval Valve System**

While AHIMA supports creation of a new code for insertion of transcatheter bioprosthetic valves in the inferior vena cava and superior vena cava, we believe the best root operation is Replacement rather than Insertion. Since there is a biologic component, Insertion is not correct because the definition specifies “putting in a **nonbiological** appliance.”

Although the bicaval valves are not physically replacing the tricuspid valve, the description of the technology in the topic packet states that they are intended to “replace the function of the defective regurgitant tricuspid valve.” The definition of the root operation Replacement states “Putting in or on biological or synthetic material that physically takes the place **and/or function** of all or a portion of a body part.” Since the bicaval valves are taking over the function of the tricuspid valve, we believe Replacement is the most appropriate root operation. “Bicaval” could be added as a Qualifier to identify the unique nature of this device.

## **Intubated Prone Positioning**

We do **NOT** support creating a code to describe intubated prone positioning. Positioning a patient, regardless of the reason, does not represent a procedure that is reportable with an ICD-10-PCS code.

## **Administration of Lovotibeglogene Autotemcel (lovo-cel)**

AHIMA supports the creation of new codes in section X New Technology, to identify the intravenous transfusion of lovo-cel.

## **Use of National Drug Codes (NDCs) to Identify Cases Involving Use of Therapeutic Agents Approved for New Technology Add-on Payment**

AHIMA is disappointed by CMS’ decision in the Fiscal Year (FY) 2023 Hospital Inpatient Prospective Payment System (IPPS) Final Rule (“final rule”) to not finalize its proposed policy to utilize only NDCs to identify claims involving the administration of therapeutic agents approved for the NTAP. As explained in further detail below, we disagree with concerns expressed by commenters in response to the FY 2023 IPPS proposed rule (“proposed rule”). **We urge CMS to move forward with the proposed policy, with a transitional period for FY 2023 and full implementation in FY 2024.**

A number of individuals and organizations have expressed support for the use of NDC codes to identify the administration of therapeutic agents, at C&M meetings, in C&M comments, and in response to the proposed rule. As CMS stated in both the proposed and final rules, CMS has received a number of comments from interested parties, including representatives from hospital associations, software vendors, professional societies, and coding professionals, opposing the continued creation of new ICD-10-PCS procedure codes for the purpose of administering the NTAP for drugs and biologics. Public comments have consistently noted that the ICD-10-PCS classification system was not intended to represent unique drugs/therapeutic agents and is not an appropriate code set for this purpose. As commenters have pointed out, many hospitals currently do not bill some NTAP-eligible drugs due to the cumbersome process and amount of the anticipated reimbursement.

Some commenters did not appear to fully understand CMS’ proposed policy or the current process of using ICD-10-PCS codes to identify therapeutic agents, nor did they seem to be aware of the multiple discussions

in the past concerning alternatives to using ICD-10-PCS codes for administration of drugs/therapeutic agents. Alternative options to using NDCs have been raised in the past, but the majority of commenters had supported using NDCs as the best alternative option, resulting in CMS' proposal in the proposed rule. Commenters requested CMS provide additional information in rulemaking on how NDCs would be utilized, including if this policy would apply specifically for therapeutic agents eligible for the NTAP or for all therapeutic agents used in Medicare, and how a drug product with multiple NDCs would be handled. However, CMS stated in the proposed rule that the proposed policy to use NDCs would only apply to the use of therapeutic agents approved for the NTAP. CMS also stated that for each drug/therapeutic agent approved for the NTAP, they would indicate the NDC(s) to use to identify applicable cases.

We disagree with suggestions that the process to educate hospitals and subsequently require NDCs might create a greater administrative burden than it would save. **AHIMA does not believe the current process of using ICD-10-PCS codes is less administratively burdensome than using NDCs**, especially when the use of NDCs has previously been established as an alternative code set and successfully used in the past to identify the same types of technologies that would be subject to the proposed policy. Some commenters may not have been familiar with the very burdensome current process for developing, maintaining, and using ICD-10-PCS codes to identify drugs/therapeutic agents approved for the NTAP. This process is very time- and resource-intensive. The administration of drugs/therapeutic agents is not typically coded in the inpatient hospital setting unless they are approved for the NTAP. Coding professionals must be educated on which drugs/therapeutic agents have been approved for the NTAP and must become familiar with the associated ICD-10-PCS codes and where to find them in the classification. Locating the supporting medical record documentation is often time-consuming, as this documentation can be difficult to find because it is in a non-intuitive location or a part of the record coding professionals do not typically access. For these reasons, these codes are often under-reported. Additionally, vendors must incorporate these ICD-10-PCS codes into their coding products and other applications, and programmers must maintain codes that may be seldom reported on inpatient claims. ICD-10-PCS codes are frequently created unnecessarily when the drug/therapeutic agents do not receive approval for the NTAP, which wastes the extensive time, effort, and resources required to create and maintain these ICD-10-PCS codes.

We disagree with the suggestion that because there are multiple proposed exposed exceptions to the use of NDCs, the streamlining and burden reduction of this policy may be limited. The only proposed exceptions were claims involving therapeutic agents that are not assigned an NDC by the Food and Drug Administration and cases involving the use of CAR T-cell and other immunotherapies that may be assigned to MS-DRG 018. AHIMA believes the current process of assigning ICD-10-PCS codes is more burdensome than managing these exceptions.

We question how valid or widespread some of the issues raised in the FY 2023 IPPS final rule because they differ from others' viewpoints or experiences. While some commenters felt that reporting NDCs would pose an administrative burden, others indicated that hospitals typically capture all NDCs related to the patient stay within their electronic health record systems, and so these codes could easily be included on claims. Commenters in favor of CMS' proposed policy stated that using NDCs would allow for superior data capture and eliminate manual intervention to complete coding, and was even a path toward earlier access to innovative therapies by Medicare beneficiaries, whereas others thought use of NDCs would be too administratively burdensome. A recommendation that CMS re-evaluate its proposal to transition to the use of NDCs because it would add undue burden on coding professionals who typically do not assign ICD-10-PCS codes for drug administration for inpatient cases does not make sense, as CMS' proposed policy would relieve the burden on coding professionals by no longer requiring them to report ICD-10-PCS codes to identify the administration of drugs/therapeutic agents approved for the NTAP. Some commenters suggested using NDCs would create new operational burdens for smaller and rural hospitals in particular,

but many drugs/therapeutic agents approved for the NTAP are complex drugs that would not typically be administered in smaller or rural hospitals. Since the use of NDCs has already previously been established as an alternative code set for the purpose of administering the NTAP in circumstances when an ICD-10-PCS code was not available to uniquely identify the use of this technology, NDCs have already been successfully used for the same purpose as described in CMS' proposed policy.

For the reasons described above, **we urge CMS to move forward with implementation of the proposed policy to use NDCs to identify cases involving the use of drugs/therapeutic agents approved for the NTAP.**

Thank you for the opportunity to comment on the proposed ICD-10-PCS modifications. If you have any questions, please feel free to contact Sue Bowman, Senior Director of Coding Policy and Compliance, at (312) 233-1115 or [sue.bowman@ahima.org](mailto:sue.bowman@ahima.org).

Sincerely,

A handwritten signature in cursive script that reads "Wylecia Wiggs Harris".

Wylecia Wiggs Harris, PhD, CAE  
Chief Executive Officer