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Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically to <http://www.regulations.gov>

Dear Administrator Oz:

On behalf of the American Health Information Management Association (AHIMA), we are writing in response to the Centers for Medicare & Medicaid Services (CMS) Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH) published in the February 27, 2026 [Federal Register](#) (CMS-6098-NC).

AHIMA is a global nonprofit association of health information (HI) professionals, with over 61,000 members and more than 88,500 credentials in the field. 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 clinicians. Leaders within AHIMA work at the intersection of healthcare, technology, and business, occupying data integrity and information privacy job functions worldwide.

E. Reducing Risks from Non-Participating Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Suppliers in Medicare Advantage and F. Reducing Fraudulent Medicare Parts A and B (Traditional Medicare) Claim Submissions

CMS seeks feedback on non-participating DMEPOS suppliers in Medicare Advantage and how to improve payment accuracy and efficiency between suppliers and plans. CMS also seeks feedback on how a shorter claim filing deadline would impact healthcare organizations, whether a shorter claim filing deadline should be implemented for certain high-risk items and services versus all items and services, and what flexibilities would need to be considered to support a transition to a shorter claim filing deadline.

HI professionals are the key individuals involved in and managing the workflows surrounding claims filing and claims processing in healthcare provider organizations, payer organizations, and DMEPOS supplier organizations. AHIMA applauds CMS for its efforts to preserve the integrity and efficiency in claims filing and the provision of DMEPOS items and services. We also welcome and stand ready to support CMS in its efforts to study and improve areas susceptible to fraud. As CMS works to improve these processes, we caution CMS that a transition to a claim filing deadline shorter than one year is infeasible, does not address the root issues related to fraud, waste, and abuse in claims submissions, and would exacerbate burden on all entities involved.

A shorter deadline for claims filing is unworkable, particularly for a majority of DMEPOS services and items, and does not reflect the complicated nature of the current process. Documentation requirements for many claims are already burdensome for healthcare providers, plans, and suppliers. DMEPOS items and services require a range of documentation and requirements, including individual rules and regulations, local coverage determinations (LCDs), physician review and approval of LCDs, face-to-face evaluations, prior authorizations, delivery requirements, and more. Securing approvals and documentation for all the needed steps to ensure patients are getting the products and services they need requires ongoing coordination and communication between all entities, which often takes months. Simultaneously, providers, suppliers, and plans are often unaware of or unable to keep up with the different levels of documentation needed to demonstrate medical necessity and fulfill a claim for DMEPOS items and services. These processes require extensive follow-up and revisions to claims, and can cause delayed payment and thus delayed provision of these needed items and services to patients. A shorter timeline would only exacerbate these burdens.

Additionally, it is unclear how such a change in the claim filing deadlines would impact pre-approved claims, appealed claims, and conditional claims, including appeals for services that receive prior approval for outpatient services when the patient was admitted to an inpatient facility. Often, appeals are initiated during an inpatient stay but are not resolved until after the patient is discharged. Furthermore, a final claim may not be able to be submitted if it is currently undergoing an appeal process. Additionally, the timeline for submitting conditional claims is 120 days, any further reduction would not be feasible for conditional claims, particularly those that are third party liability related as timely action by the other entities involved are beyond the control of the healthcare provider.

AHIMA recommends CMS gather additional information on all items and services provided in Medicare, including DMEPOS, to understand which areas are more susceptible to inaccuracies. The Medicare enrollment application and process for DMEPOS suppliers is one avenue that CMS can use to gather information on the products and services provided in different areas. It is important to note that both healthcare providers and DMEPOS suppliers care for and serve patients in wide geographic areas, and often across state lines. A high occurrence of claims related to a particular item or service does not necessarily indicate fraud, waste, or abuse. By understanding the distribution and complexity across items and services CMS can better understand where to target efforts to promote integrity within the claims process.

Additionally, CMS should consider revisiting and restructuring the Medicare enrollment application and accreditation form for DMEPOS suppliers to ensure the appropriate items and services are included. Since this form is to be updated regularly with any change in the supplier's items or services provided (among other changes), it provides CMS a method for collecting updated information on the transparency of items and services provided by suppliers. With that information, CMS can better understand the breadth of patients that healthcare organizations, Medicare plans, and DMEPOS suppliers serve, and can find ways to identify high-risk items and services and target efforts appropriately.

AHIMA believes the best path forward to address fraud, waste, and abuse is to identify recurring occurrences of fraud by first gathering information on items and services deemed high-risk. With input from healthcare organizations, Medicare plans, and DMEPOS suppliers, these definitions of high-risk items and services should be provided to the healthcare community and updated regularly. This allows CMS to collect ample information to adjust requirements and processes. Second, CMS should work to streamline the documentation requirements and address the burden associated with claims submissions, particularly for DMEPOS items and services. This includes ensuring requirements are clearly understood by healthcare providers, plans, and suppliers, as well as ensuring documentation and coding appropriately matches the products or services ordered by healthcare

providers and provided by suppliers. CMS should consider working with healthcare providers, plans, suppliers, and electronic health record (EHR) vendors to introduce digital tools and technologies, including artificial intelligence (AI) with appropriate human oversight, to provide insight into misalignment in documentation and identify documentation needs to facilitate smooth claim filing. AHIMA remains ready to assist CMS in these activities to further the nationwide goal of increasing efficiency while decreasing fraud.

G. Artificial Intelligence in Medicare Advantage Coding Oversight and Hospital Billing

CMS seeks feedback on the application of AI solutions to assist human medical coders with large volumes of records, improve accuracy, incorporate coder feedback, and prevent errors. CMS seeks feedback on how AI-generated coding recommendations should be displayed to human reviewers, compliance risks, and lessons learned from implementing AI solutions.

HI professionals continue to be some of the most experienced individuals in healthcare organizations using AI. Computer assisted coding and autonomous coding tools have been used for over 10 years with HI professionals leaning on these automation tools to relieve burden and enable HI professionals to focus on the patient records and related documentation needing additional attention. While these tools have provided many benefits to the HI professional, additional guardrails are needed to ensure organizations understand the work tools are engaging in, how patient data is being used to generate outputs, and how to gauge the accuracy of the tools.

AI holds great promise for healthcare operations, when used appropriately, and with human oversight and review. No AI solution should independently make coding determinations, but the supervised use of such technologies could be helpful in reducing the burden associated with large volumes of records and claims. Along these lines, AHIMA encourages CMS to consider the varying experience levels, resource and staff availability, and access to such technologies of different entities when incorporating AI into its programs. This includes CMS' own use of AI for program integrity, requiring plans or providers to use it, or implementing policy goals that are only attainable using AI. CMS, health insurance plans, and providers must work together to ensure AI tools are appropriate for the task assigned to them. AHIMA remains ready to assist CMS in diagnosing the regulatory guardrails needed for non-clinical AI solutions and finding common sense regulatory solutions to address those needs.

What types of AI solutions (including commercial off-the-shelf (COTS) products) are most effective and efficient for assisting human coders with large volumes of records?

In 2023, AHIMA, in partnership with NORC at the University of Chicago, released a report titled *Health Information Workforce: Survey Results on Workforce Challenges and the Role of Emerging Technologies*.¹ The report surveyed HI professionals and covered trends in the HI workforce, while also asking questions related to the use of non-clinical AI and the types of tools HI professionals are using regularly. Over 80% of respondents to the survey indicated they are using computer assisted coding tools within their departments. When asked about the overall benefits of utilizing all AI, including computer assisted coding, respondents indicated that AI tools alleviated staff burnout, reduced administrative burden, improved productivity, decreased claims denials, improved compliance, and in some cases improved data quality.

The AI technologies cited most as improving productivity, while also mitigating burnout, were computer assisted coding tools, autonomous coding tools, administrative workflow assistance, and healthcare utilization management, as well as several others cited in the study. Despite the use of these tools, respondents noted that

¹Available at: <https://www.norc.org/content/dam/norc-org/pdf2023/AHIMA-Workforce-Survey-Report-Final-2023.pdf>.

many of them require human oversight to ensure quality is maintained, as well as to ensure regulatory alignment. This oversight can create increased technical burden as it relates to implementing and maintaining the products.

Part of that technical burden relates to the needed customization for these tools to align with each organization's specific needs. COTS products provide a baseline set of services, but each organization's structure and operational and clinical needs create an environment where COTS products may be unable to provide either the outputs, or the oversight abilities an organization requires. While some COTS products, for functions like computer assisted coding, can be used easily with little customization, tools for activities such as patient matching need to be customized to the organization's records environment and the organization's risk tolerance for patient matching accuracy. While future COTS tools may be able to be one size fits all, healthcare is currently not in the position to utilize such tools at scale. Until the way healthcare is practiced and paid for and data is moved in a more ubiquitous interoperable manner, COTS AI products will struggle to meet the needs of every organization without customization.

If CMS were to pursue promoting or utilizing COTS products for solutions relating to coding large volumes of records those tools should include guardrails and logic accounting for proper context in coding, such as widely adopted coding guidelines. Additionally, the systems must include robust analytics modules to provide feedback to organizations on the accuracy of the tools. While some AHIMA members report that coding tools maintain 70% alignment with human coders, an analytics module can ensure those high levels of alignment can be preserved and improved long-term. Even though there may be no one size fits all solution for medical coding, ensuring products maintain these two baseline features will ensure broad alignment across the healthcare system.

What key features and learning capabilities should an AI solution include to improve accuracy, incorporate coder feedback, and prevent errors or "hallucinations"?

AHIMA recommends CMS engage in robust conversation with the end-users of AI technologies to understand the scope of end-user needs and create pathways for end-users to be included in the development of AI technologies earlier than they are now. Currently, technology is developed with minimal input from the end-user perspective. End-users often have their first experiences with a piece of technology as it is being implemented into their organization and they begin receiving training on how to use that technology. With AI needing to possess the capability to learn and evolve over time, end-users need to be brought to the table earlier as those technologies are planned for and developed. Without robust end-user development, any learning capabilities an AI may possess could be misdirected and fail to meet the needs of an end-user.

As end-users are incorporated into the development process, particular focus should be placed on the ability for AI tools to maintain predictable outputs dictated by human input. While it is important for AI technologies to be able to operate with little oversight, that operation must continue within a predetermined set of parameters. Healthcare operations function within strict limits and requirements. While those needs may evolve overtime, it is imperative for AI tools to operate in predictable manners in order for end-users to maintain high levels of trust. If an AI tool were to function differently every time it is used, it would require additional oversight and place burden on the end-user to ensure the differences are not contributing to inaccuracy in the health record and even worse, poor outcomes for the patient.

With those strict parameters in place, HI professionals have indicated there are a number of areas where AI tools should evolve over the technology's lifespan. Areas where learning should be best represented include, but are not limited to, when the tool auto selects for the recommended best code to fit a procedure and when the tool reads a

clinical note and determines it does not require a code. These evolutions should be limited and contain checks and balances where a human is able to review and approve the changes long-term.

HI professionals also stated there is a need for tools to be layered with different functions and specializations to ensure specific coding guidelines are followed. Part of that layering should include ensuring the systems maintain functionality to receive routine updates to the coding guidelines on a schedule similar to when human coders receive those updates. It will be crucial that AI tools are able to utilize the coding guidelines to identify the correct information within unstructured data maintaining contextual awareness to ensure accuracy is maintained long-term. Finally, it is crucial for the tools to identify when medical coding decision making is done by an AI tool or by a human.

By ensuring there are strict guardrails in place with the ability of end-users to maintain strict oversight over an AI tool, the fear of long-term or large hallucinations can be mitigated. If, however, an end-user is not involved in the creation of the AI tool or in maintaining its operations, then hallucinations may go unchecked with no ability for the end-user to understand the status of the AI's operations and make adjustments. If this were to happen, patients may be put at risk with the potential for AI tools to code incorrect medical information. Errors such as this will add cost to the healthcare system as it will need to dedicate time and resources to unwind potentially complex errors across different areas. Appropriate oversight policies with guardrails can ensure complex errors do not continue in perpetuity allowing organizations to identify issues and rectify them quickly.

How should AI-generated coding recommendations be displayed to human reviewers, and what compliance risks should be considered and mitigated?

AHIMA recommends CMS work with the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) to determine the best way of representing AI transparency tools within certified health IT and its ancillary systems. Previously, ASTP/ONC included AI transparency tools as part of the electronic health record (EHR) under its decision support interventions (DSI) criteria within the health IT certification program. In the Health Data, Technology, and Interoperability: Deregulatory Actions to Unleash Prosperity (HTI-5) proposed rule, ASTP/ONC proposed to remove that transparency criteria. AHIMA opposed the proposal and recommended ASTP/ONC maintain the DSI criteria and build upon it to further hone its scope and usefulness. CMS should work with ASTP/ONC to preserve the DSI criteria as an avenue to include recommendations for medical coders, and other AI related information suggestions.

Additionally, AHIMA recommends CMS consult end-users via a notice of proposed rulemaking process focused on ways to display transparent recommendations from AI systems. By soliciting input from end-users, CMS can create policy solutions that are more likely to succeed once implemented. If CMS were to move forward without input from end-users, it runs the risk of creating policy changes that fail in real-world environments.

HI professionals indicated there are a number of crucial needs related to displaying recommendations for human reviewers that CMS should take into account for any future action. This includes ensuring the tool displays the pathway to how a medical code was identified and where in the medical record the corresponding supporting documentation is located. Additionally, a confidence score based on that documentation to help reviewers prioritize which codes need to be reviewed will be crucial to have included in any AI tool to ensure trust is maintained in AI coding tools. Finally, all coding tools must maintain an audit process with reporting mechanisms to ensure transparency and eliminate concerns about “black box” problems in understanding how the tools are making decisions. AHIMA and its members remain committed to assisting CMS in understanding the needs for these tools to ensure successful AI use in healthcare.

Are there AI solutions that address coding issues related to overpayments and underpayments, and can those AI solutions be used for compliance oversight?

AI solutions exist to ensure medical coding is accurate and that corresponding reimbursement is appropriate. These solutions are only as successful as the guardrails placed around them and the process validation flow used to ensure the solution is operating appropriately. AHIMA recommends CMS propose a robust set of guardrails for the use of AI that encompasses the full scope of end-users needs to ensure AI tools alleviate burden to avoid excessive oversight due to the lack of transparency and accuracy from a tool.

For example, an AHIMA member at a large health system stated they had utilized an AI tool to refund patients that had been inappropriately charged. It was a relatively easy task, with limited need for human oversight. Once deployed, the tool began refunding patients the tool believed to be inappropriately charged. Appropriate guardrail and oversight tools were not in place for this organization and as a result, the AI refunded all patients, not just those who were originally marked as needing to be refunded. If CMS were to recommend or require the use of AI solutions to address coding issues related to overpayments and underpayments, without requiring the appropriate guardrails and oversight, it is possible for similar errors to occur across the nation. AI can only function as well as the guardrails and oversight placed upon it. CMS should engage extensively with the necessary stakeholders, including coding and clinical documentation improvement (CDI) specialists about the challenges of utilizing AI for these processes prior to any action that may require this technology's implementation and use.

How could AI be used to increase the efficiency and accuracy of hospital billing?

AI tools for hospital billing, as stated above, relating to overpayments and underpayments, are only as effective as the guardrails and oversight tools given to the end-users of those tools. If end-users are unable to see and understand how a tool is functioning or provide oversight to that function, then the tool is at risk for lower accuracy and lower efficiency for hospital billing. AI contains tremendous promise for alleviating the “easy” use cases from an HI professional's workflow, but if those use cases are handled poorly by the AI the workload will only increase as rework will be required. AHIMA recommends CMS proceed with a request for information and proposed rule process if it were to consider regulating the use of AI for hospital billing. It will be crucial for CMS to gain a full understanding of the realities of using these tools from end-users if it is to propose successful regulation for implementation and use. Not doing so risks burden and cost being elevated across healthcare as organizations work with inadequate or unregulated AI tools.

Thank you for the opportunity to comment on the RFI. AHIMA remains committed to improving the provision and integrity of government programs through policies that streamline claims filing and processing requirements and appropriately leverage AI. If AHIMA may provide any further information, or if there are any questions, please contact Andrew Tomlinson, senior director of regulatory and international affairs at Andrew.Tomlinson@ahima.org or Tara O'Donnell, manager of regulatory affairs at Tara.Odonnell@ahima.org.

Sincerely,



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