



233 N. Michigan Ave., 21st Fl.
Chicago, IL 60601

phone » (312) 233-1100
fax » (312) 233-1090
web » www.ahima.org

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Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
Attention: **CMS-1752-P**
PO Box 8011
Baltimore, Maryland 21244-1850

Dear Administrator Brooks-LaSure:

On behalf of the American Health Information Management Association (AHIMA), I am responding to the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the Medicare Hospital Inpatient Prospective Payment Systems (IPPS) and fiscal year 2022 rates, as published in the May 10, 2021 *Federal Register* (CMS-1752-P).

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. AHIMA's 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.

Following are our comments and recommendations on selected sections of the IPPS proposed rule.

II. PROPOSED CHANGES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (86FR25090)

II-D – Proposed Changes to Specific MS-DRG Classifications (86FR25091)

II-D-1b – Basis for Proposed FY 2022 MS-DRG Updates (86FR25091)

AHIMA supports a change to the deadline for requesting updates to the MS-DRGs from November 1 to October 20. **We further recommend that CMS consider instituting a second submission date for earlier in the calendar year.** While requests for changes to the MS-DRG classifications may currently be submitted any time prior to the fall deadline, having a second target submission date would encourage interested parties to submit requests earlier in the year rather than waiting until the final deadline. Staggered submission of MS-DRG change requests would allow CMS the

additional time needed to carefully evaluate the requested changes, analyze claims data, and consider any proposed updates.

AHIMA recommends that CMS assess whether additional funding and staffing are needed to fully evaluate MS-DRG change requests, analyze claims data, and proposed updates, and seek additional resources if necessary. As CMS stated in the proposed rule, the number and complexity of the requested changes to the MS-DRG classifications has continued to increase since the adoption of ICD-10 MS-DRGs.

II-D-2 – Pre-MDC: MS-DRG 018 Chimeric Antigen Receptor (CAR) T-cell Therapy
(86FR25094)

We support the proposed revisions to MS-DRG 018 (Chimeric Antigen Receptor [CAR] T-cell Immunotherapy).

II-D-3a – MDC 03 (Diseases and Disorders of the Ear, Nose and Throat): Major Head and Neck Procedures (86FR25096)

AHIMA supports the reassignment of three procedure codes describing excision of subcutaneous tissue of chest, back, or abdomen from MS-DRGs 140, 141, and 142 (Major Head and Neck Procedures with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 143, 144, and 145 (Other Ear, Nose, Mouth And Throat O.R. Procedures with MCC, with CC, and without CC/MCC, respectively).

II-D-3b – MDC 03 (Diseases and Disorders of the Ear, Nose and Throat): Other Ear, Nose, Mouth and Throat O.R. Procedures (86FR25097)

AHIMA continues to believe that some procedure codes currently classified to MS-DRGs 143, 144, and 145 (Other Ear, Nose, Mouth And Throat O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) do not belong in these MS-DRGs because they describe procedures performed on body parts other than the ear, nose, and throat. A list of the procedure codes we recommend CMS consider removing from the logic for MS-DRGs 143, 144, and 145 is found in Attachment A. Procedure codes for skin grafts and related procedures as well as codes for control of bleeding in the cranial cavity are not included on this list because we acknowledge that these procedures may reasonably be expected to be performed on patients classified to MDC 03.

CMS stated in its rationale for proposing to maintain the structure of MS-DRGs 143, 144, and 145 that the “other” surgical category contains surgical procedures which, while infrequent, could still reasonably be expected to be performed for a patient in the particular MDC. We understand this might be the case with procedure codes describing skin grafts and control of bleeding in the cranial cavity, but it is much less clear why procedures listed in Attachment A of this letter would be expected to be performed for patients in MDC 03. Therefore, we believe it is reasonable to consider removing procedure codes from the logic for MS-DRGs 143, 144, and 145 that are not clinically

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aligned, in terms of the body system or body part they are performed on, with other procedures in these MS-DRGs that describe procedures performed on the ear, nose, mouth, and throat.

II-D-4a – MDC 04 (Diseases and Disorders of the Respiratory System): Bronchiectasis
(86FR25098)

AHIMA agrees with CMS' proposal to maintain the structure of MS-DRGs 190, 191, and 192 (Chronic Obstructive Pulmonary Disease with MCC, with CC, and without CC/MCC, respectively).

II-D-4b – MDC 04 (Diseases and Disorders of the Respiratory System): Major Chest Procedures (86FR25098)

AHIMA supports the proposed reassignment of 17 procedure codes from their current MS-DRG assignments in MDC 04 and other MDCs to more clinically appropriate MDCs and MS-DRGs.

We support removing procedure codes describing repair of esophagus from the logic in MDC 04.

We also support reassignment of nine procedure codes describing repair of pulmonary or thoracic structures and 17 procedure codes describing procedures performed on the sternum or ribs from MS-DRGs 166, 167, and 168 (Other Respiratory System O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 163, 164, and 165 (Major Chest Procedures with MCC, with CC and without CC/MCC, respectively) in MDC 04.

II-D-5a – MDC 05 (Diseases and Disorders of the Circulatory System): Short-term External Heart Assist Device (86FR25106)

AHIMA supports the reassignment of procedure codes describing the intraoperative insertion of a short-term external heart assist device from MS-DRG 215 (Other Heart Assist System Implant) to MS-DRGs 216, 217, 218 (Cardiac Valve and Other Major Cardiothoracic Procedures with Cardiac Catheterization with MCC, with CC, and without CC/MCC, respectively), and MS-DRGs 219, 220 and 221 (Cardiac Valve and Other Major Cardiothoracic Procedures without Cardiac Catheterization with MCC, with CC, and without CC/MCC, respectively).

II-D-5b – MDC 05 (Diseases and Disorders of the Circulatory System): Type II Myocardial Infarction (86FR25115)

We agree with CMS' proposed modifications to the GROUPER logic to allow cases reporting diagnosis code I21.A1 (Myocardial infarction type 2) as a secondary diagnosis to group to MS-DRGs 222 and 223 (Cardiac Defibrillator Implant with Cardiac Catheterization with AMI, HF or Shock with and without MCC, respectively) when reported with qualifying procedures. As CMS stated in the proposed rule, coding rules stipulate that diagnosis code I21.A1 must be reported as a secondary diagnosis.

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II-D-5c – MDC 05 (Diseases and Disorders of the Circulatory System): Viral Cardiomyopathy
(86FR25116)

We support the proposed reassignment of ICD-10-CM diagnosis code B33.24, Viral cardiomyopathy, from MDC 18 in MS DRGs 865 and 866 (Viral Illness with and without MCC, respectively) to MDC 05 in MS DRGs 314, 315, and 316 (Other Circulatory System Diagnoses with MCC, with CC, and without CC/MCC, respectively). This change will improve clinical coherence since the other codes in subcategory B33.2 are already assigned to MDC 05.

II-D-6a – MDC 08 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Knee Joint Procedures (86FR25122)

We agree with the proposed addition of three procedure code combinations describing removal and replacement of the right knee joint that were inadvertently omitted from the logic to MS-DRGs 461, 462, 466, 467, and 468 (Revision of Hip or Knee Replacement with MCC, with CC, and without CC/MCC, respectively) in MDC 08 and MS-DRGs 628, 629, and 630 (Other Endocrine, Nutritional and Metabolic O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) in MDC 10.

II-D-7 – MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract): Continuous Renal Replacement Therapy (CRRT) (86FR25128)

AHIMA agrees that new MS-DRGs should not be created for continuous renal replacement therapy without regard to principal diagnosis.

II-D-8 – MDC 16 (Diseases and Disorders of Blood, Blood Forming Organs and Immunologic Disorders): Cytokine Release Syndrome (CRS) Logic (86FR25146)

We support the proposed revision of the structure of MS-DRGs 814, 815, and 816 (Reticuloendothelial and Immunity Disorders with MCC, with CC, and without CC/MCC, respectively) by removing the logic that includes a principal diagnosis of T80.89XA, Complication of immune effector cellular therapy, with a secondary diagnosis of any cytokine release syndrome code from MS-DRGs 814, 815, and 816, effective FY 2022.

Note there is a typographical error in the code number listed in the proposed rule that needs to be corrected – it should be code T80.89XA, not T89.89XA.

We also support the assignment of new diagnosis code T80.82XA to MDC 16 in MS-DRGs 814, 815, and 816.

II-D-9 – MDC 17 (Myeloproliferative Diseases and Disorders, and Poorly Differentiated Neoplasms): Inferior Vena Cava Filter Procedures (86FR25147)

We agree with CMS’ proposal to maintain the current structure of MS-DRGs 829 and 830 (Myeloproliferative Disorders or Poorly Differentiated Neoplasms with Other Procedures with and without CC/MCC, respectively) and not create a three-way severity level split.

II-D-10 – Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989 (86FR25149)

We agree with the following proposed changes:

- Add three procedure codes describing control of bleeding in the cranial cavity to MDC 01 in MS-DRGs 23, 24, 25, 26, and 27 (“craniotomy” MS-DRGs).
- Designate three procedure codes describing open excision of subcutaneous tissue and fascia of chest, back, abdomen, as non-extensive procedures.
- Designate procedure codes describing laser interstitial thermal therapy of various body parts as non-extensive procedures.
- Designate three procedure codes describing repair of esophagus via percutaneous, natural or artificial opening, and natural or artificial opening endoscopic approach, as non-extensive procedures.
- Designate one procedure code describing open drainage of urethra as a non-extensive procedure.

II-D-11b(1) – Operating Room (O.R.) and Non-O.R. Issues: O.R. Procedures to Non-O.R. Procedures - Open Drainage of Subcutaneous Tissue and Fascia (86FR25158)

AHIMA supports removing 22 procedure codes describing open drainage of subcutaneous tissue and fascia from the O.R. procedure list.

II-D-11c(1) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures - Percutaneous Introduction of Substance into Cranial Cavity and Brain (86FR25161)

We agree that a procedure code describing percutaneous introduction of eladocogene exuparvec into the cranial cavity and brain should be designated as an O.R. procedure. This designation would be consistent with other percutaneous procedures performed on the cranial cavity and brain body parts.

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II-D-11c(2) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures - Open Drainage of Maxilla and Mandible (86FR25161)

We support maintaining the current non-O.R. designation for procedure codes describing open drainage of maxilla or mandible.

II-D-11c(3) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures - Thoracoscopic Extirpation of Pleural Cavities (86FR25161)

We agree with CMS’ proposal to maintain the current non-O.R. designation of procedure codes for thoracoscopic extirpation of pleural cavities.

II-D-11c(4) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Open Pleural Biopsy (86FR25162)

We support designating two procedure codes describing open pleural biopsy as O.R. procedures. We agree that open excision of pleura regardless of whether it is performed for diagnostic or therapeutic purposes should have the same O.R. procedure designation.

II-D-11c(5) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Percutaneous Revision of Intraluminal Devices (86FR25162)

AHIMA agrees with the proposed designation of five procedure codes describing percutaneous revision of intraluminal vascular devices as O.R. procedures.

II-D-11c(6) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Occlusion of Left Atrial Appendage (86FR25163)

We support maintaining the current non-O.R. designation of procedure codes describing left atrial appendage closure.

II-D-11c(7) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Arthroscopic Drainage of Joints (86FR25164)

We support maintaining the current non-O.R. designation of procedure codes describing percutaneous endoscopic drainage of shoulder, knee, and hip joints.

II-D-11c(8) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Arthroscopic Irrigation of Joints (86FR25164)

We support maintaining the current non-O.R. designation of procedure codes describing arthroscopic irrigation of joints.

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II-D-11c(9) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Percutaneous Reposition with Internal Fixation (86FR25164)

AHIMA agrees that four procedure codes describing percutaneous repositioning with internal fixation in the sacroiliac and hip joints should be designated as O.R. procedures.

II-D-11c(10) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Open Insertion and Removal of Spacer into Shoulder Joint (86FR25165)

We agree that eight procedure codes describing the insertion or removal of a spacer in the shoulder joint via an open or percutaneous endoscopic approach should be designated as O.R. procedures.

II-D-11c(11) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Open/Percutaneous Extirpation of Jaw (86FR25166)

We agree with designating four procedure codes describing extirpation of matter from the upper or lower jaw via an open or percutaneous endoscopic approach as O.R. procedures.

II-D-11c(12) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Open Extirpation of Subcutaneous Tissue and Fascia (86FR25166)

AHIMA supports designating 22 procedure codes describing open extirpation of matter from the subcutaneous tissue and fascia as O.R. procedures.

II-D-11c(13) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Open Revision and Removal of Devices from Subcutaneous Tissue and Fascia (86FR25167)

We support maintaining the non-O.R. designation of procedure codes describing open revision and removal of neurostimulator generators, monitoring devices, and totally implantable vascular access devices.

II-D-11c(14) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Open Insertion of Feeding Device (86FR25168)

We agree that neither the procedure code describing open insertion of feeding device into stomach nor the procedure code describing open insertion of feeding device into jejunum should be designated as an O.R. procedure.

II-D-11c(15) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Laparoscopic Insertion of Feeding Tube (86FR25169)

We support maintaining the non-O.R. designation of procedure codes describing laparoscopic insertion of feeding device into stomach and jejunum. AHIMA agrees that all procedures that

describe the percutaneous endoscopic insertion of a feeding device in the gastrointestinal system should continue to have the same non-O.R. designation.

II-D-11c(16) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Endoscopic Fragmentation and Extirpation of Matter of Urinary Tract (86FR25169)

We support maintaining the non-O.R. designation of procedure codes describing fragmentation in the kidney pelvis, ureter, bladder, and bladder neck via natural or artificial opening endoscopic approach.

We also support maintaining the non-O.R. designation of two procedure codes describing endoscopic extirpation of matter from the bladder and bladder neck and removing six procedure codes describing endoscopic extirpation of matter from the kidney, kidney pelvis, and ureter from the O.R. procedure list. We agree that procedures describing endoscopic extirpation from a urinary body part should all have the same non-O.R. designation.

II-D-11c(17) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Endoscopic Removal of Ureteral Stent (86FR25171)

AHIMA agrees that a procedure code describing removal of intraluminal device from ureter, via natural or artificial opening endoscopic approach, should continue to be designated as a non-O.R. procedure.

II-D-11c(18) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Endoscopic/Transorifice Inspection of Ureter (86FR25171)

We support maintaining the non-O.R. designation of a procedure code describing inspection of ureter, via natural or artificial opening endoscopic approach.

II-D-11c(19) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Endoscopic Biopsy of Ureter and Kidney (86FR25171)

We agree that the current non-O.R. designation for six procedure codes describing endoscopic biopsy procedures performed on the ureter and kidney structures should be maintained.

II-D-11c(20) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Transorifice Insertion of Ureteral Stent (86FR25172)

We support maintaining the non-O.R. designation of three procedure codes describing dilation of ureter with intraluminal device via natural or artificial opening.

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II-D-11c(21) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Percutaneous Insertion of Ureteral Stent (86FR25172)

We support maintaining the non-O.R. designation of three procedure codes describing percutaneous dilation of ureter with intraluminal device.

II-D-11c(22) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Endoscopic Dilation of Urethra (86FR25173)

We agree that the current non-O.R. designation for a procedure code describing dilation of urethra with intraluminal device, via natural or artificial opening endoscopic approach, should be maintained.

II-D-11c(23) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Open Repair of Scrotum (86FR25173)

AHIMA supports maintaining the non-O.R. designation of a procedure code describing open repair of scrotum.

II-D-11c(24) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Open Drainage of Vestibular Gland (86FR25173)

We agree that procedure codes describing drainage of the vestibular gland should be designated as non-O.R. procedures.

II-D-11c(25) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Transvaginal Repair of Vagina (86FR25173)

We support maintaining the non-O.R. designation of a procedure code describing repair of vagina via natural or artificial opening.

II-D-11c(26) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Percutaneous Tunneled Vascular Access Devices (86FR25174)

We support maintaining the non-O.R. designation of 10 procedure codes describing percutaneous insertion of tunneled vascular access devices into various body parts.

II-D-12c – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2022: Potential Change to Severity Level Designation for Unspecified Diagnosis Codes for FY 2022 (86FR25175)

AHIMA fully supports CMS' proposal to change the severity level designation of "unspecified" diagnosis codes to a non-CC when there are more specific codes available in that code subcategory that recognize laterality. We agree that reporting the most specific diagnosis codes supported by the available medical record documentation and clinical knowledge of the patient's health condition

would more accurately reflect the healthcare encounter and improve the reliability and validity of the coded data.

We also support making the proposed change in the severity level designation for these “unspecified” codes effective for FY 2022. It is reasonable to expect laterality to be documented in the hospital inpatient setting in most cases. Since the implementation of ICD-10-CM and ICD-10-PCS, AHIMA has advocated for healthcare providers to capture complete and accurate clinical documentation in order to leverage the benefits of the expanded level of specificity and clinical detail in these code sets. For example:

- AHIMA’s *Standards of Ethical Coding*¹ state “Coding professionals shall assist with and educate providers, clinicians, and others by advocating proper documentation practices and further specificity for both diagnoses and procedures when needed to more precisely reflect the acuity, severity, and the occurrence of events.”
- AHIMA’s *Ethical Standards for Clinical Documentation Integrity Professionals*² state “Query the provider for clarification when documentation in the health record impacts an externally reportable data element and is illegible, incomplete, unclear, inconsistent, or imprecise. The clinical documentation must reflect an accurate and concise representation of the patient’s clinical condition(s).”
- AHIMA’s Inpatient Query Toolkit³ states that it may be appropriate to generate a provider query when documentation in the patient’s record fails to meet one of several criteria, including “precision.” According to this toolkit, a provider query should be considered if laterality cannot be determined from the documentation.

We commend CMS for taking steps to leverage the additional specificity available in ICD-10-CM by fostering the reporting of the most specific diagnosis codes supported by the available medical record documentation and clinical knowledge of the patient’s health condition. The anticipated benefits of the ICD-10-CM transition (including better data for measuring quality and safety of patient care, assessing patient outcomes, determining disease severity for risk and severity adjustment, and conducting analyses and research) cannot be realized if healthcare encounters are not coded and documented to the highest possible level of specificity.

II-D-12d – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2022: Proposed Additions and Deletions to the Diagnosis Code Severity Levels for FY 2022 (86FR25180)

We support the proposed additions and deletions to the MCC and CC lists.

¹ AHIMA, *Standards of Ethical Coding*. Available at <http://bok.ahima.org/doc?oid=302237#.YMe4TPIKhPZ>.

² AHIMA, *Ethical Standards for Clinical Documentation Integrity Professionals*. Available at https://www.ahima.org/media/r2gmhlop/ethical-standards-for-clinical-documentation-integrity-cdi-professionals-2020.pdf?oid=301868#.X0-1TxNKg_U

³ AHIMA, *Inpatient Query Toolkit*. Available at <http://bok.ahima.org/PdfView?oid=302896>.

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II-D-12e – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2022: Proposed CC Exclusions List for FY 2022 (86FR25180)

We support the proposed changes to the CC Exclusions List.

II-D-14a – Proposed Changes to the Medicare Code Editor (MCE): External Causes of Morbidity Codes as Principal Diagnosis (86FR25186)

AHIMA supports the addition of three new ICD-10-CM diagnosis codes to the External Causes of Morbidity edit code list.

II-D-14b(1) – Proposed Changes to the Medicare Code Editor (MCE): Age Conflict Edit – Pediatric Diagnoses (86FR25187)

We support the addition of two new ICD-10-CM diagnosis codes to the Pediatric Diagnoses category code list under the Age Conflict edit.

II-D-14c(1) – Proposed Changes to the Medicare Code Editor (MCE): Sex Conflict Edit – Diagnoses for Females Only (86FR25187)

AHIMA supports the addition of two new ICD-10-CM diagnosis codes to the edit code list for the Diagnoses for Females Only edit.

II-D-14d – Proposed Changes to the Medicare Code Editor (MCE): Unacceptable Principal Diagnosis Edit (86FR25187)

We support the proposed addition of new and existing diagnosis codes to the Unacceptable Principal Diagnosis edit code list. We agree that coding conventions or instructional notes prohibit the reporting of these codes as the principal diagnosis.

II-D-14e – Proposed Changes to the Medicare Code Editor (MCE): Unspecified Codes (86FR25189)

We support the creation of a new MCE edit to align with the proposal to change the severity level designation of “unspecified” diagnosis codes to a non-CC when there are other codes available in that code subcategory that further specify the anatomic site.

II-D-16 – Maintenance of the ICD-10-CM and ICD-10-PCS Coding Systems (86FR25190)

As stated in an April 30 [letter](#) to CMS and the Centers for Disease Control and Prevention/National Center for Health Statistics (CDC/NCHS), AHIMA supports the adoption of an April 1 implementation date for ICD-10-CM and ICD-10-PCS code updates in addition to the current October 1 annual update. The addition of an April 1 implementation date would ensure more timely updating of the code sets. The process and timeline set forth by CMS seem reasonable, but as

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AHIMA stated in the April 30 letter, it will be critical for CMS and CDC/NCHS to adhere to this timeline in order for the healthcare industry to have sufficient time to prepare for implementation of the April 1 code update.

AHIMA further recommended that a set of guiding principles (or criteria) be established for determining which code proposals should be implemented on April 1. Specifically, we suggested that code updates falling into one of these categories should be considered for an April 1 update:

- Codes related to the declared public health emergency (PHE);
- Addenda changes;
- Code proposals for which the public has declared an urgent need and public comments support expedited implementation;
- Code proposals that have been presented at multiple ICD-10 Coordination and Maintenance Committee meetings.

IX. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS (86FR25549)

IX-B – Closing the Health Equity Gap in CMS Hospital Quality Programs – Request for Information (86FR25554)

In recognition of persistent health disparities and the importance of closing the health equity gap, CMS requested information on making reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable. AHIMA appreciates CMS’ attention to this critical issue and supports efforts to close the health equity gap, both in the face of the ongoing pandemic and in healthcare more generally.

CMS is specifically interested in addressing “the challenges of defining and collecting, accurate and standardized, self-identified demographic information, including information on race and ethnicity, disability, and language preference for the purposes of reporting, measure stratification, and other data collection efforts relating to quality.”

AHIMA supports the standardized collection of accurate and complete patient demographic and social determinants of health data and notes that this data must be collected in ways that are culturally appropriate and community competent with an understanding of the community being served and related needs.

AHIMA also recommends that the agency prioritize addressing workforce development needs to ensure that the healthcare workforce is more equipped to consistently and accurately collect patients’ demographic information in ways that are culturally sensitive. A culturally competent healthcare workforce will be critical in overcoming historical mistrust of healthcare institutions within certain communities. We also note that data on sexual orientation and gender identity is

frequently not collected at the time of admission. AHIMA recommends working to ensure that there is a standardized methodology in place to capture these demographic elements since a patient's gender identity or sexual orientation may change over time.

AHIMA also recognizes the role of technology in closing the health equity gap. We recommend leveraging technology to analyze quality-of-care and outcomes using both patient demographics and clinical data to identify and address disparities. This should include promoting the development of machine-learning and artificial intelligence techniques that identify and address biases in the data and avoid exacerbating existing health disparities and inequities.

IX-F – Proposed Changes to the Medicare and Medicaid Promoting Interoperability Programs (86FR25628)

AHIMA appreciates CMS' focus on improving nationwide interoperability, as well as the agency's understanding of the need for continued flexibility, particularly in light of the ongoing PHE. We offer the following comments related to the proposed changes to the Promoting Interoperability (PI) programs.

IX-F-2 – Proposed Changes to the Medicare and Medicaid Promoting Interoperability Programs: EHR Reporting Period (86FR25628)

For calendar year (CY) 2024, CMS is proposing an electronic health record (EHR) reporting period of a minimum of any continuous 180-day period for new and returning participants in the PI program. This is an increase from the current EHR reporting period which is currently a minimum of any continuous 90-day period. Although AHIMA appreciates that the agency is allowing for multiple years of advanced notice prior to implementation, we are concerned with the additional burdens that would stem from an expanded reporting period. As the COVID-19 PHE continues, the resources of hospitals and critical-access hospitals (CAHs) will continue to be strained due to staffing shortages. AHIMA believes that during the PHE and in its immediate aftermath, the primary focus of hospitals and CAHs should be on providing patient care and recovering from the impacts of the pandemic, rather than adjusting to comply with potentially burdensome regulatory requirements. As such, AHIMA urges CMS to consider delaying implementing more stringent requirements until facilities have had sufficient time to recover from the impacts of the PHE.

IX-F-3 – Proposed Changes to the Medicare and Medicaid Promoting Interoperability Programs: Proposed Changes to Query of Prescription Drug Monitoring Program under the Electronic Prescribing Objective (86FR25629)

The agency is proposing for the EHR reporting period in CY 2022 to maintain the Electronic Prescribing Objective's Query of PDMP measure as optional while increasing its associated bonus points from five points to 10 points. AHIMA appreciates that the increase of the measure's associated bonus points to 10 points is consistent with the policy finalized for Merit-based Incentive Payment System (MIPS) eligible clinicians in the CY 2021 PFS final rule and would be in alignment with the MIPS PI performance category. AHIMA agrees that this measure should remain

optional until exchange can be more uniformly supported across healthcare system stakeholders. In previous comments, AHIMA has stated operational concerns with fully integrating health information technology systems with PDMPs and agrees that this measure should remain optional until these issues can be addressed.

IX-F-4 – Proposed Changes to the Medicare and Medicaid Promoting Interoperability Programs: Proposed Changes to the Provide Patients Electronic Access to Their Health Information Measure Under the Provider to Patient Exchange Objective (86FR25631)

CMS is proposing to modify the Provide Patients Electronic Access to Their Health Information measure to require eligible hospitals and CAHs to ensure that patient health information remains accessible indefinitely and using any application of their choice that is configured to meet the technical specifications of the API in the eligible hospital or CAH's Certified Electronic Health Record Technology (CEHRT). The proposed requirement would apply beginning with the EHR reporting period in CY 2022 and would include all patient health information from encounters on or after January 1, 2016. AHIMA has significant concerns with this proposal and urges the agency to rescind the proposed requirement.

Specifically, AHIMA is concerned with the administrative burdens, costs, and security risks associated with making information available indefinitely. AHIMA believes that this proposed requirement does not align with existing policies and standards at most healthcare facilities. We note that historically regulations regarding record retention have not contained indefinite requirements.^{4,5} As such, the need to maintain records from old systems in perpetuity is likely to place substantial administrative burdens on PI participants and HIM professionals.

Going forward into the future, AHIMA is concerned with how this requirement will age and believes that there are likely to be substantial costs associated with maintaining records in numerous legacy systems, dating back to 2016. AHIMA also believes there are likely to be elevated risks associated with ensuring the security of decades-old records that were created on decades-old systems. AHIMA also requests clarification on the auditing process for this measure. How long will PI program participants need to keep documentation after this measure is completed and submitted?

AHIMA members also have expressed concerns related to retrieval of records using archival systems and we note that many archival systems lack public facing capabilities. Absent this capability, it may be difficult and burdensome to make an archived record available to patients on demand in electronic format. AHIMA members believe that a majority of archival systems were not chosen with public facing capabilities in mind. This requirement effectively would require additional functionality from archival systems, which is not presently available, and which may impose additional costs on PI participants. Additionally, there are likely to be issues associated with

⁴ Pritts, Joy, et al. Office of the National Coordinator for Health IT, Aug. 2009. Privacy and Security Solutions for Interoperable Health Information Exchange.

⁵ Condition of participation: Medical record services, 42 CFR §482.24.

data conversion as our members report that the data sets that are converted are usually smaller than what would be required under this proposal.

Continuing, AHIMA requests clarification on the term “all patient health information.” It is unclear to AHIMA whether this term would refer to the designated record set, the elements included in the United States Core Data for Interoperability (USCDI), or potentially a broader set of information. AHIMA believes that there is an opportunity for harmonization with requirements contained in other recently finalized rules, including the ONC 21st Century Cures Act Final Rule, and urges the agency to clarify this term. Absent this clarification, this requirement is likely to lead to undue burden and confusion on HIM professionals and PI program participants.

For decades, AHIMA has been concerned with the lack of specific guidance from both federal and state regulators about record retention, regardless of their format. States can have multiple, conflicting retention laws if they have any at all. Currently, there is a patchwork of state and few federal retention requirements that are confusing to our members. While AHIMA welcomes standardized, retention timeline guidance, we are deeply concerned about having an “indefinite” requirement.

Finally, AHIMA is concerned with the retrospective nature of this proposal. As this proposal would apply to encounters dating back to January 1, 2016, this proposal would effectively punish PI program participants for failure to prepare for a requirement that they could not have possibly been aware of at the time. AHIMA notes that, absent a statutory requirement, retroactive requirements are only allowed in cases in which “failure to apply the change retroactively would be contrary to the public interest.”⁶ AHIMA believes that given the above stated operational challenges, this new requirement may fail to meet this threshold.

IX-F-5 – Proposed Changes to the Medicare and Medicaid Promoting Interoperability Programs: Health Information Exchange Objective: Engagement in Bi-directional Exchange Through Health Information Exchange (HIE) (86FR25631)

AHIMA supports the proposed inclusion of the new bi-directional exchange measure as an optional alternative to the two existing measures. AHIMA supports that the new measure may be reported by yes/no attestation. AHIMA concurs with CMS’ rationale that the new measure can support robust health information exchange while minimizing the burden on hospitals and patients to be individually accountable to facilitate exchange via multiple connections. AHIMA concurs with the agency that inclusion of this new optional measure can help promote engagement in health information exchange across the care continuum. AHIMA also agrees that this measure will encourage bi-directional exchange of health information with community partners to promote care coordination for patients with chronic conditions and complex care needs.

Continuing, AHIMA recognizes that the care continuum is broader than existing PI program participants and increased bi-directional exchange of health information could help facilitate care

⁶ 42 U.S.C. § 1395hh(e)(1)(A)

coordination. As such, CMS should take into consideration the fact that there are care settings that may lack certain technical capabilities and struggle with bi-directional exchange of patients' electronic health information compared to PI program participants.

IX-F-6 – Proposed Changes to the Medicare and Medicaid Promoting Interoperability Programs: Health Information Exchange Objective: Modifications to the Public Health and Clinical Data Exchange Objective (86FR25634)

CMS is proposing significant modifications to the Public Health and Clinical Data Exchange objective. Specifically, the agency is proposing to require four of the measures associated with the Public Health and Clinical Data Exchange Objective, beginning with the EHR reporting period in CY 2022: Syndromic Surveillance Reporting; Immunization Registry Reporting; Electronic Case Reporting; and Electronic Reportable Laboratory Result Reporting.

As such, beginning with the EHR reporting period in CY 2022, an eligible hospital or CAH would receive 10 points for the Public Health and Clinical Data Exchange objective if they report a “yes” response for each of the four required measures. Failure to report on any one of the four measures required for this objective, failure to claim relevant exclusions or reporting a “no” response for one or more of these measures, would result in a score of zero for the Public Health and Clinical Data Exchange objective, and a total score of zero for the PI program. The agency is also proposing to retain the existing Public Health Registry Reporting and Clinical Data Registry Reporting measures and to make them optional and available for a maximum of five bonus points beginning with the EHR reporting period in CY 2022.

AHIMA supports the proposed modifications of this objective, noting that significant strides have been made in electronic case reporting throughout the PHE, that have enabled those that previously lacked the resources to conduct electronic case reporting to do so. AHIMA concurs that the proposed modifications to the objective could better prepare the healthcare system for future health threats and long-term pandemic recovery by strengthening critical public health functions. AHIMA believes it is appropriate to keep the remaining measures under this objective available for bonus points.

IX-F-8 – Proposed Changes to the Medicare and Medicaid Promoting Interoperability Programs: SAFER Guides (86FR25638)

CMS is proposing to add a new SAFER Guides measure to the Protect Patient Health Information objective beginning with the CY 2022 EHR reporting period. For this measure, an eligible hospital or CAH must attest to having conducted an annual self-assessment of all nine SAFER Guides at any point during the calendar year in which the EHR reporting period occurs, with one “yes/no” attestation statement accounting for a complete self-assessment using all nine guides. The agency also proposes that this measure would be required, but it would not be scored, and that reporting “yes” or “no” will not affect the total score for the PI Program. AHIMA agrees with the agency that this measure will encourage program participants to regularly assess their progress on practices to optimize the safety and safe use of EHRs. AHIMA supports CMS' proposals to make this measure

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unscored and so that attesting to either a “yes” or “no” will not impact the participant’s total PI score.

IX-F-9 – Proposed Changes to the Medicare and Medicaid Promoting Interoperability Programs: Actions to Limit or Restrict the Compatibility or Interoperability of CEHRT (86FR25639)

AHIMA supports CMS’ proposal to no longer require that PI program participants attest to two of the three previously codified attestation requirements to support the “prevention of information blocking.” AHIMA concurs with CMS’ rationale that “similarities between practices described under statements 2 and 3, and the practices that could constitute information blocking under section 3022 of the PHSA and ONC’s implementing regulations will create confusion for stakeholders.”

AHIMA agrees with CMS that requirements under the ONC Cures Act Final Rule are broader and as such, make the existing attestation statements that CMS is proposing to eliminate redundant. AHIMA supports the requirement that program participants must still attest to the statement that the participant “Did not knowingly and willfully take action (such as to disable functionality) to limit or restrict the compatibility or interoperability of certified EHR technology.”

If AHIMA can provide any further information, or if there are any questions regarding this letter and its recommendations, please feel free to contact Sue Bowman, senior director of coding policy and compliance, at (312) 233-1115 or sue.bowman@ahima.org.

Sincerely,



Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer

ATTACHMENT A

ICD-10-PCS procedure codes that describe procedures that do not appear to be clinically appropriate for assignment to MS-DRGs 143-145	
ICD-10-PCS Procedure Code	Code Description
02JA4ZZ	Inspection of heart, percutaneous endoscopic approach
02JY4ZZ	Inspection of great vessel, percutaneous endoscopic approach
06HY0DZ	Insertion of intraluminal device into lower vein, open approach
06HY3DZ	Insertion of intraluminal device into lower vein, percutaneous approach
06HY4DZ	Insertion of intraluminal device into lower vein, percutaneous endoscopic approach
07B50ZZ	Excision of right axillary lymphatic, open approach
07B53ZZ	Excision of right axillary lymphatic, percutaneous approach
07B54ZZ	Excision of right axillary lymphatic, percutaneous endoscopic approach
07B60ZZ	Excision of left axillary lymphatic, open approach
07B63ZZ	Excision of left axillary lymphatic, percutaneous approach
07B64ZZ	Excision of left axillary lymphatic, percutaneous endoscopic approach
07T30ZZ	Resection of right upper extremity lymphatic, open approach
07T34ZZ	Resection of right upper extremity lymphatic, percutaneous endoscopic approach
07T40ZZ	Resection of left upper extremity lymphatic, open approach
07T80ZZ	Resection of right internal mammary lymphatic, open approach
07T84ZZ	Resection of right internal mammary lymphatic, percutaneous endoscopic approach
07T90ZZ	Resection of left internal mammary lymphatic, open approach
07T94ZZ	Resection of left internal mammary lymphatic, percutaneous endoscopic approach
07TB0ZZ	Resection of mesenteric lymphatic, open approach
07TB4ZZ	Resection of mesenteric lymphatic, percutaneous endoscopic approach
07TF0ZZ	Resection of right lower extremity lymphatic, open approach
07TF4ZZ	Resection of right lower extremity lymphatic, percutaneous endoscopic approach
07TG0ZZ	Resection of left lower extremity lymphatic, open approach
07TG4ZZ	Resection of left lower extremity lymphatic, percutaneous endoscopic approach
0DJ04ZZ	Inspection of upper intestinal tract, percutaneous endoscopic approach
0F900ZX	Drainage of liver, open approach, diagnostic
0F910ZX	Drainage of right lobe liver, open approach, diagnostic

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0F920ZX	Drainage of left lobe liver, open approach, diagnostic
0FB00ZX	Excision of liver, open approach, diagnostic
0FB10ZX	Excision of right lobe liver, open approach, diagnostic
0FB20ZX	Excision of left lobe liver, open approach, diagnostic
0PB40ZZ	Excision of thoracic vertebra, open approach
0PB43ZZ	Excision of thoracic vertebra, percutaneous approach
0PB44ZZ	Excision of thoracic vertebra, percutaneous endoscopic approach
0QB00ZZ	Excision of lumbar vertebra, open approach
0QB03ZZ	Excision of lumbar vertebra, percutaneous approach
0QB04ZZ	Excision of lumbar vertebra, percutaneous endoscopic approach