American Health Information Management Association®

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August 11, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
Attention: CMS-1766-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 rule for the Calendar Year (CY) 2023 Home Health Prospective Payment System Rate (HH PPS) Update, as published in the June 23, 2022, Federal Register (CMS-1766-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.

II. HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (87FR37603)

II-B-3c(1) – Proposed Reassignment of Specific ICD-10-CM Codes Under the PDGM: Proposed Clinical Reassignment of Certain Unspecified Diagnosis Codes (87FR37621)

AHIMA urges CMS to reconsider its proposal to reassign 159 ICD-10-CM unspecified diagnosis codes to "no clinical group" (NA). AHIMA fully supports complete and accurate documentation and coding, including coding to the highest specificity possible. However, there are valid circumstances when unspecified codes can and should be used. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when unspecified codes are the best choices for accurately reflecting the healthcare encounter. As stated in the *ICD-10-CM Official Guidelines for Coding and Reporting* ("official coding guidelines"), when sufficient clinical information isn't known or available

about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code. Also according to the official coding guidelines, while codes for unspecified laterality should rarely be used, there are circumstances when these codes are appropriate, such as when the documentation in the record is insufficient to determine the affected side and it is not possible to obtain clarification.

The burden of obtaining the necessary information to support the reporting of more specific codes than those on the proposed list of unspecified codes will be challenging for home health organizations. While some home health organizations may have access to complete hospital medical records through system integration, others without this linkage may find it difficult or impossible to obtain the information needed to support greater coding specificity. Many home health services are provided as a "subsequent encounter," meaning active treatment for the initial injury has been completed, and so anatomic specificity regarding the original injury may not be included in the home health documentation. Requiring providers to use specific codes when the clinical information to support a more specific code isn't available may encourage providers to select a specific code without supporting medical record documentation.

The proposed rule references the new Medicare Code Editor (MCE) edit for unspecified diagnosis codes that is part of the Hospital Inpatient Prospective Payment System (IPPS). However, the codes subject to this edit are still considered acceptable principal diagnoses under certain circumstances. If additional information to identify laterality is unable to be obtained or there is documentation that the physician is clinically unable to determine the laterality because of the nature of the disease/condition, then the provider must enter that information in the claim remarks field. This information enables the Medicare Administrative Contractor to bypass the edit and process the claim accordingly. Therefore, reimbursement is not affected by the unspecified diagnosis code if the hospital affirms that information to support a more specific code could not be obtained.

The diagnosis codes subject to the "unspecified code" MCE edit and the list of codes in table 1.A associated with the HH PPS proposed rule are not consistent. A majority (114) of the 159 codes on the home health list are not subject to the MCE edit. While the discussion in the HH PPS proposed rule focuses on laterality, not all of the proposed codes on the list pertain to unspecified laterality. For example, codes N70.91, Salpingitis, unspecified, and N70.92, Oophoritis, unspecified, are on the list, but the missing specificity for these codes is acuity rather than laterality.

AHIMA agrees with CMS that all clinical conditions should be documented and coded to the highest degree of specificity possible. However, as CMS acknowledged in its implementation of the "unspecified code" MCE edit, it is not always possible to avoid using an unspecified code. We do not believe it is appropriate for home health providers to be held to a higher standard for coding specificity than inpatient hospitals, especially since the documentation to support specific codes is more likely to be found in hospital inpatient documentation than in home health documentation.

To encourage home health providers to report specific codes and to document the clinical detail necessary to support these codes, AHIMA recommends that CMS consider implementing an edit similar to the MCE edit, which would promote coding specificity while still allowing the use of unspecified codes when necessary. As CMS did with the implementation of the MCE edit, implementation of such an edit should be delayed for a period of time to allow home health organizations time to educate providers and coding staff. We recommend that only codes describing unspecified laterality should initially be subject to this edit in order to allow a transition period for documentation and coding improvement

efforts to be effective before considering expansion to additional unspecified codes. This would be consistent with CMS' approach for unspecified codes under the IPPS.

If AHIMA can provide any further information, or if there are any questions regarding our 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