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Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1694-P**
PO Box 8011
Baltimore, Maryland 21244-1850

Dear Administrator Verma:

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 2019 rates, published as a notice of proposed rulemaking (NPRM) in the May 7, 2018, *Federal Register* (CMS-1694-P).

AHIMA is a not-for-profit, membership-based healthcare association representing more than 103,000 health information professionals who work in more than 40 different types of entities related to our nation's healthcare and public health industry. AHIMA members are experts in the diagnosis and procedure classifications on which the MS-DRGs used in the IPPS are based. Our members are also deeply involved with the development and analysis of healthcare secondary reporting data and in the development, planning, implementation and management of electronic health records. As part of our effort to promote consistent coding practices, AHIMA serves as one of the Cooperating Parties, who oversee development of official guidance associated with the proper use of the ICD-10-CM and ICD-10-PCS code sets. The other three Cooperating Parties are CMS, the National Center for Health Statistics (NCHS), and the American Hospital Association (AHA).

Our comments and recommendations on selected sections of the IPPS NPRM are below.

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II. Proposed Changes to Medicare Severity Diagnosis-Related Group (MS-DRG) Classifications and Relative Weights (83FR20176)

II-F – Proposed Changes to Specific MS-DRG Classifications (83FR20177)

II-F-2a – Pre-MDC: Heart Transplant or Implant of Heart Assist System (83FR20178)

AHIMA supports CMS' decision to maintain the current structure of MS-DRGs 001 and 002 (Heart Transplant or Implant of Heart Assist System with and without MCC, respectively), MS-DRG 215 (Other Heart Assist System Implant), and MS-DRGs 268 and 269 (Aortic and Heart Assist Procedures Except Pulsation Balloon with and without MCC, respectively), and to continue to analyze claims data. We agree with CMS that current claims data do not yet reflect recent advice published in *Coding Clinic for ICD-10-CM/PCS* regarding the coding of procedures involving external heart assist devices or recent changes to ICD-10-PCS codes for these procedures.

We also support CMS' decision not to reassign cases in which the use of ECMO is reported with the insertion of a percutaneous short-term external heart assist device.

II-F-2b – Pre-MDC: Brachytherapy (83FR20188)

We agree with CMS' proposal not to create a new MS-DRG for procedures involving the CivaSheet[®] technology.

II-F-2c – Pre-MDC: Laryngectomy (83FR20188)

AHIMA supports CMS' proposal to reorder the lists of diagnosis and procedure codes for MS-DRGs 11, 12, and 13 (Tracheostomy for Face, Mouth and Neck Diagnoses with MCC, with CC, and without CC/MCC, respectively) in the MS-DRG Definitions Manual, in order to clarify the Grouper logic.

We also support the proposed revision of the titles of MS-DRGs 11, 12, and 13 to reflect that laryngectomy procedures are also classified to these MS-DRGs.

II-F-2d – Pre-MDC: Chimeric Antigen Receptor (CAR) T-Cell Therapy (83FR20188)

We support the proposed assignment of ICD-10-PCS code for CAR T-cell therapy to MS-DRG 016 and to revise the title of this MS-DRG accordingly. Once sufficient data becomes available, further analysis should be conducted to determine if another MS-DRG would be more appropriate or if a unique MS-DRG should be created.

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II-F-3a – MDC 1 (Diseases and Disorders of the Nervous System): Epilepsy with Neurostimulator (83FR19825)

We support the addition of ICD-10-CM codes G40.109 and G40.111 to the listing of epilepsy codes for cases assign to MS-DRG 023 (Craniotomy with Major Device Implant or Acute Complex Central Nervous System (CNS) Principal Diagnosis (PDX) with MCC or Chemotherapy Implant or Epilepsy with Neurostimulator).

II-F-3b – MDC 1 (Diseases and Disorders of the Nervous System): Neurological Conditions With Mechanical Ventilation (83FR20190)

While we recognize CMS' rationale for not creating new MS-DRGs for cases that identify patients diagnosed with neurological conditions who require mechanical ventilation, we encourage CMS to conduct additional analysis to come up with an approach for refining the MS-DRGs for cases involving mechanical ventilation across MDCs in the future.

According to the *ICD-10-CM Official Guidelines for Coding and Reporting*, when two or more conditions equally meet the criteria for principal diagnosis, any one of the diagnoses may be sequenced first. In this situation, since coded data are used for many purposes other than reimbursement, selection of the most appropriate principal diagnosis that satisfies all of these purposes can be challenging.

II-F-4a – MDC 5 (Diseases and Disorders of the Circulatory System): Pacemaker Insertions (83FR20197)

AHIMA supports the proposed designation of the code combination of insertion of a pacemaker device and insertion of pacemaker lead as O.R. procedures outside of MDC 5 and the designation of either of these procedures as non-O.R. procedures when reported as a single, individual stand-alone code.

We recommend that the procedure codes on page 20204 of the proposed rule that describe the removal or revision of a cardiac lead and removal or revision of a cardiac rhythm-related device be designated as non-O.R. procedure codes when reported as a single, individual stand-alone code with a principal diagnosis outside of MDC 5 to ensure consistency in the classification of pacemaker procedures.

We further recommend that the insertion of intracardiac or “leadless” pacemakers should also be classified into all surgical unrelated MS-DRGs outside of MDC 5.

II-F-4b – MDC 5 (Diseases and Disorders of the Circulatory System): Drug-Coated Balloons in Endovascular Procedures (83FR20205)

We support maintaining the current classification of cases involving the use of a drug-coated balloon in the performance of endovascular procedures. We recommend that further data

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analysis be conducted after the new ICD-10-PCS codes for endovascular procedure utilizing a drug-coated balloon in the upper extremity go into effect on October 1, 2018, in order to determine if MS-DRG modifications are warranted.

II-F-5a – MDC 6 (Diseases and Disorders of the Digestive System): Benign Lipomatous Neoplasm of Kidney (83FR20207)

We agree with the proposed reassignment of ICD-10-CM codes D17.71, Benign lipomatous neoplasm of kidney, and D17.72, Benign lipomatous neoplasm of other genitourinary organ, to MS-DRGs 686, 687, and 688 (Kidney and Urinary Tract Neoplasms with MCC, with CC, and without CC/MCC, respectively).

II-F-5b – MDC 8 (Diseases and Disorders of the Digestive System): Bowel Procedures (83FR20208)

AHIMA **opposes** the proposed MS-DRG reassignment of 12 ICD-10-PCS codes describing certain bowel procedures. We recommend that changes to these MS-DRGs be delayed until a thorough data analysis is conducted. This analysis should include review of the principal diagnoses for cases involving these ICD-10-PCS codes, as the associated diagnosis significantly impacts the resource utilization and complexity. For example, the root operation “Reposition” may be used for the takedown of a stoma as well as to treat a specific medical condition such as malrotation of the intestine. “Repair” is the root operation of last resort, when no other ICD-10-PCS root operation applies, and so it is used for a wide range of procedures of varying complexity.

It seems clinically inconsistent to consider a simple ileostomy closure (e.g., ICD-10-PCS code 0DBB0ZZ, Excision of ileum, open approach), a Major Bowel Procedure while a more complex procedure, such as closure of a Hartmann end stoma (e.g., ICD-10-PCS code 0DSM4ZZ, Reposition descending colon, percutaneous endoscopic approach), would be grouped to a Minor Bowel Procedure.

Also, several questions and answers regarding these ICD-10-PCS codes were published in *Coding Clinic for ICD-10-CM/PCS* between late 2016 and the end of 2017. Since two full years of data were not available subsequent to publication of this advice, CMS’ analysis and proposed MS-DRG modifications may be based on unreliable data.

II-F-6 – MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Spinal Fusion (83FR20209)

AHIMA agrees with CMS’ proposal not to make any changes to the MS-DRGs involving spinal fusion procedures for FY 2019.

Regarding claims data showing inaccuracies in the coding of spinal fusions, there has been some confusion around the proper coding of these procedures. In particular, based on questions

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published recently in *Coding Clinic for ICD-10-CM/PCS*, there has been confusion as to whether a spinal fusion code could be assigned when no bone graft or bone graft substitute is used (e.g., instrumentation only), but the medical record documentation refers to the procedure as a spinal fusion. While *Coding Clinic for ICD-10-CM/PCS* has attempted to clarify proper spinal fusion coding, we believe confusion continues to persist.

We recommend that refinements be made to the ICD-10-PCS spinal fusion coding guidelines in order to further clarify appropriate reporting of spinal fusion codes and ensure consistency between the guidelines and *Coding Clinic* advice.

II-F-7 – MDC 9 (Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast): Cellulitis with Methicillin Resistant Staphylococcus Aureus (MRSA) Infection (83FR20212)

We agree with CMS' proposal to maintain the current MS-DRG classification for cases reported with ICD-10-CM diagnosis codes B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere, and A49.02, Methicillin resistant Staphylococcus aureus infection, unspecified site.

II-F-8 – MDC 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders): Acute Intermittent Porphyria (83FR20212)

We support maintaining the current MS-DRG classification for cases reported with ICD-10-CM code E80.21, Acute intermittent (hepatic) porphyria.

II-F-9 – MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract): Admit for Renal Dialysis (83FR20213)

AHIMA supports deletion of MS-DRG 685 (Admit for Renal Dialysis).

II-F-10 – MDC 14 (Pregnancy, Childbirth, and the Puerperium) (83FR20214)

We support the proposed refinement and re-structuring of the obstetric MS-DRGs. The proposed changes significantly improve the structure and logic of these MS-DRGs and result in a set of MS-DRGs that are much simpler and clearer than the current version.

II-F-11 – MDC 18 (Infectious and Parasitic Diseases (Systematic or Unspecified Sites)): Systematic Inflammatory Response Syndrome (SIRS) of Non-Infectious Origin (83FR20226)

AHIMA supports the proposed reassignment of ICD-10-CM codes R65.10, Systemic Inflammatory Response Syndrome (SIRS) of non-infectious origin without acute organ dysfunction, and R65.11, Systemic Inflammatory Response Syndrome (SIRS) of non-infectious origin with acute organ dysfunction, to MS-DRG 864 and retitling this MS-DRG to "Fever and Inflammatory Conditions."

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II-F-12 – MDC 21 (Injuries, Poisonings and Toxic Effects of Drugs): Corrosive Burns
(83FR20227)

We support maintaining the current MS-DRG assignment for cases involving a primary diagnosis of toxic effect and a secondary diagnosis of corrosive burn.

II-F-13a(1) – Proposed Changes to the Medicare Code Editor (MCE): Age Conflict Edit – Perinatal/Newborn Diagnoses (83FR20229)

We agree with the proposed addition of the four Z05 diagnosis codes listed on pages 20229-20230 of the proposed rule to the Age Conflict edit under the Perinatal/Newborn Diagnoses Category edit code list.

II-F-13a(2) – Proposed Changes to the Medicare Code Editor (MCE): Age Conflict Edit – Pediatric Diagnoses Category (83FR20230)

We agree that ICD-10-CM code Z13.4, Encounter for screening for certain developmental disorders in childhood, should be removed from the Pediatric Diagnoses Category edit code list, as this code is no longer valid effective October 1, 2018.

II-F-13a(3) – Proposed Changes to the Medicare Code Editor (MCE): Age Conflict Edit – Maternity Diagnoses (83FR20230)

AHIMA supports the addition of new ICD-10-CM codes associated with pregnancy and maternal care to the list of diagnosis codes for the Maternity Diagnoses category under the Age Conflict edit.

We also support the removal of ICD-10-CM codes F53, Puerperal psychosis, and O86.0, Infection of obstetric surgical wound, from the Maternity Diagnoses Category edit code list, as they are no longer valid effective October 1, 2018.

II-F-13b(1) – Proposed Changes to the Medicare Code Editor (MCE): Sex Conflict Edit – Diagnoses for Females Only (83FR20231)

We support the addition of ICD-10-CM codes Z30.015, Encounter for initial prescription of vaginal ring hormonal contraceptive, Z31.7, Encounter for procreative management and counseling for gestational carrier, and Z98.891, History of uterine scar from previous surgery, as well as new codes for conditions consistent with the female sex, to the Diagnoses for Females Only edit code list under the Sex Conflict edit.

We also support the removal of ICD-10-CM codes F53, Puerperal psychosis, O86.0, Infection of obstetric surgical wound, and Q51.2, Other doubling of uterus, from the Diagnoses for Females Only edit code list, as they are no longer valid effective October 1, 2018.

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There are two typographical errors in the list of invalid codes being removed from this edit code list at the top of page 20232 of the proposed rule. The second code should be O86.0 (not O86.00) and the third code should be Q51.2 (not Q51.20).

II-F-13b(2) – Proposed Changes to the Medicare Code Editor (MCE): Sex Conflict Edit – Procedures for Females Only (83FR20232)

We support the addition of new ICD-10-CM codes describing procedures associated with the female sex to the Procedures for Females Only edit code list.

II-F-13b(3) – Proposed Changes to the Medicare Code Editor (MCE): Sex Conflict Edit – Diagnoses for Males Only (83FR20232)

We support the addition of new ICD-10-CM codes describing conditions consistent with the male sex to the Diagnoses for Males Only edit code list under the Sex Conflict edit.

II-F-13c – Proposed Changes to the Medicare Code Editor (MCE): Manifestation Code as Principal Diagnosis Edit (83FR20232)

We support the addition of new ICD-10-CM codes K82.A1, Gangrene of gallbladder in cholecystitis, and K82.A2, Perforation of gallbladder in cholecystitis, to the Manifestation Code as Principal Diagnosis edit code list.

II-F-13d – Proposed Changes to the Medicare Code Editor (MCE): Questionable Admission Edit (83FR20233)

We support the creation of a new “Questionable Obstetric Admission” edit under the Questionable Admission edit. We agree that an outcome of delivery diagnosis code should be reported for every admission when a delivery has occurred.

However, **we recommend that the following two codes be deleted from this proposed edit:**

10D17Z9 Manual Extraction of Products of Conception, Retained, Via Natural or Artificial Opening
10D18Z9 Manual Extraction of Products of Conception, Retained, Via Natural or Artificial Opening Endoscopic

We believe patients may be admitted for treatment of retained products of conception subsequent to the delivery admission.

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II-F-13e – Proposed Changes to the Medicare Code Editor (MCE): Unacceptable Principal Diagnosis Edit (83FR20234)

AHIMA supports the proposed addition of ICD-10-CM code Z49.01, Encounter for fitting and adjustment of extracorporeal dialysis catheter, to the Unacceptable Principal Diagnosis edit code list.

We also support the deletion of ICD-10-CM code Z13.4, Encounter for screening for certain developmental disorders in childhood, from this list, as it will be an invalid code effective October 1, 2018.

II-F-14 – Proposed Changes to Surgical Hierarchies (83FR20235)

We support the proposed revisions to the surgical hierarchy for MDC 14 (Pregnancy, Childbirth, and the Puerperium).

II-F-15b – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2019: Proposed Additions and Deletions to the Diagnosis Code Severity Levels for FY 2019 (83FR20236)

AHIMA supports the proposed additions and deletions to the MCC and CC severity levels for FY 2019.

II-F-15c – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2019: Principal Diagnosis Is Its Own CC or MCC (83FR20236)

We support deletion of the special logic in the Grouper for processing claims containing a diagnosis code from the Principal Diagnosis Is Its Own CC or MCC Lists. These lists were created to facilitate replication of the ICD-9-CM MS-DRGs and are an artifact of the ICD-10 transition. As noted by CMS in the proposed rule, this approach is no longer necessary because ICD-10-CM/PCS data are now available.

II-F-15d – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2019: Proposed CC Exclusions List for FY 2019 (83FR20239)

We support the proposed modifications to the CC Exclusions List for FY 2019.

II-F-16b(1) – Comprehensive Review of CC List for FY 2019: Requested Changes to Severity Levels – Human Immunodeficiency Virus [HIV] Disease (83FR20241)

AHIMA disagrees with the proposed change in severity level of ICD-10-CM code B20, Human immunodeficiency virus [HIV] disease, from an MCC to a CC, as CMS' data analysis did not strongly suggest that the current severity categorization was inaccurate.

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II-F-16b(2) – Comprehensive Review of CC List for FY 2019: Requested Changes to Severity Levels – Acute Respiratory Distress Syndrome (83FR20241)

AHIMA supports changing the severity level of ICD-10-CM code J80, Acute respiratory distress syndrome, from a CC to an MCC.

II-F-16b(3) – Comprehensive Review of CC List for FY 2019: Requested Changes to Severity Levels – Encephalopathy (83FR20241)

AHIMA supports maintaining the current severity level of ICD-10-CM code G93.40, Encephalopathy, unspecified.

II-F-17c – Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989: Adding Diagnosis or Procedure Codes to MDCs (83FR120242)

We support the proposed reassignment of seven ICD-10-CM codes describing congenital musculoskeletal conditions from MDC 4 (Diseases and Disorders of the Respiratory System) to MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), in MS-DRGs 564, 565, and 566 (Other Musculoskeletal System and Connective Tissue Diagnoses with MCC, with CC, and without CC/MCC, respectively).

We support reassignment of ten ICD-10-CM codes for sternal fractures to MDC 8, to MS-DRGs 564, 565, and 566.

We also support the proposed addition of eight ICD-10-PCS codes describing repositioning of rib(s) to MDC 4, in MS-DRGs 166, 167, and 168 (Other Respiratory System O.R. Procedures with MCC, with CC, and without CC/MCC, respectively).

II-F-20a – Other Policy Changes: Other Operating Room (O.R.) and Non-O.R. Issues – Percutaneous and Percutaneous Endoscopic Excision of Brain and Cerebral Ventricle (83FR20251)

We support the proposed O.R. procedure designation of 22 ICD-10-PCS codes describing procedures involving transcranial brain and cerebral ventricle excision.

II-F-20b – Other Policy Changes: Other Operating Room (O.R.) and Non-O.R. Issues – Open Extirpation of Subcutaneous Tissue and Fascia (83FR20252)

We support maintaining the non-O.R. procedure status of ICD-10-PCS codes describing procedures involving open extirpation of subcutaneous tissue and fascia.

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II-F-20c – Other Policy Changes: Other Operating Room (O.R.) and Non-O.R. Issues – Open Scrotum and Breast Procedures (83FR20252)

We support the proposed O.R. procedure designation of 13 ICD-10-PCS codes describing procedures involving open drainage, open extirpation, and open debridement/excision of the scrotum and breast.

II-F-20d – Other Policy Changes: Other Operating Room (O.R.) and Non-O.R. Issues – Open Parotid Gland and Submaxillary Gland Procedures (83FR20253)

We support the proposed O.R. procedure designation of eight ICD-10-PCS codes describing procedures involving open drainage and open extirpation of the parotid or submaxillary glands.

II-F-20e – Other Policy Changes: Other Operating Room (O.R.) and Non-O.R. Issues – Removal and Reinsertion of Spacer; Knee Joint and Hip Joint (83FR20253)

We support the proposed O.R. procedure designation of eight ICD-10-PCS codes that describe procedures involving open removal or insertion of spacer into the knee or hip joints.

II-F-20f – Other Policy Changes: Other Operating Room (O.R.) and Non-O.R. Issues – Endoscopic Dilation of Ureter(s) with Intraluminal Device (83FR20254)

We support the proposed O.R. procedure designation of three ICD-10-PCS codes that describe procedures involving endoscopic dilation of ureter(s) with intraluminal device.

II-F-20g – Other Policy Changes: Other Operating Room (O.R.) and Non-O.R. Issues – Thoracoscopic Procedures of Pericardium and Pleura (83FR20254)

We support the proposed O.R. procedure designation of nine ICD-10-PCS codes that describe procedures involving thoracoscopic drainage of the pericardial cavity or pleural cavity, or thoracoscopic or open extirpation of matter from the pleura.

II-F-20h – Other Policy Changes: Other Operating Room (O.R.) and Non-O.R. Issues – Open Insertion of Totally Implantable and Tunneled Vascular Access Devices (83FR20255)

We support the proposed O.R. procedure designation of ten ICD-10-PCS codes describing open insertion of totally implantable vascular access devices and maintaining the current non-O.R. procedure designation for codes describing open insertion of tunneled vascular access devices.

II-F-20i – Other Policy Changes: Other Operating Room (O.R.) and Non-O.R. Issues – Percutaneous Joint Reposition with Internal Fixation Device (83FR20256)

We support maintaining the non-O.R. procedure status of ICD-10-PCS codes describing procedures involving percutaneous joint reposition with internal fixation device.

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II-F-20j – Other Policy Changes: Other Operating Room (O.R.) and Non-O.R. Issues – Endoscopic Destruction of Intestine (83FR20256)

We support the proposed change from O.R. procedure designation to non-O.R. procedure for four ICD-10-PCS codes describing endoscopic destruction of the intestine.

II-F-20k – Other Policy Changes: Other Operating Room (O.R.) and Non-O.R. Issues – Drainage of Lower Lung Via Natural or Artificial Opening Endoscopic, Diagnostic (83FR20257)

We support the proposed change from O.R. procedure designation to non-O.R. procedure for five ICD-10-PCS codes describing procedures involving endoscopic drainage of the lung via natural or artificial opening for diagnostic purposes.

II-H – Proposed Add-On Payments for New Services and Technologies for FY 2019 (83FR20276)

II-H-5a – Proposed Add-On Payments for New Services and Technologies for FY 2019: FY 2019 Applications for New Technology Add-On Payments – KYMRIAHTM (Tisagenlecleucel) and YESCARTATM (Axicabtagene Ciloleucel) (83FR20284)

If both KYMRIAHTM and YESCARTATM are approved for new technology add-on payments, and it is determined that an alternative coding mechanism will be needed because the ICD-10-PCS codes do not differentiate these technologies, **we recommend that National Drug Codes (NDCs) be used for this purpose.**

IV. Other Decisions and Proposed Changes to the IPPS for Operating System (83FR20377)

IV-M – Proposed Revision of Hospital Inpatient Admission Orders Documentation Requirements Under Medicare Part A (83FR20447)

IV-M-2 – Proposed Revisions Regarding Admission Order Documentation Requirements (83FR20448)

AHIMA recommends that CMS instruct Medicare contractors not to deny payment solely on the basis of a missing inpatient admission order. We believe this would be the best solution for addressing denials due to technical discrepancies.

Written admission orders are a sound medical record documentation practice and serve a variety of purposes beyond meeting Medicare payment requirements.

VIII. Quality Data Reporting Requirements for Specific Providers and Suppliers (83FR20469)

D. Proposed Changes to the Medicare and Medicaid EHR Incentive Programs (now referred to as the Medicare and Medicaid Promoting Interoperability (PI) Programs)

In general, AHIMA appreciates the flexibility and enhanced focus on improving interoperability that CMS has proposed in the rule. That said, we would like to offer the following specific comments related to the proposed changes to the Promoting Interoperability Programs.

Certification Requirements

AHIMA supports CMS' intent under the proposed rule to require the 2015 Edition of CEHRT for the CY 2019 EHR reporting period. We believe the community in general is ready to utilize technology that is certified to the 2015 Edition and that this requirement will serve to advance interoperability and improve the access, exchange, and use of health data. That said, we recognize that there may be circumstances in which rural eligible hospitals and/or critical access hospitals (CAHs) may lack the budgetary resources necessary to transition to the 2015 Edition for CY 2019. **For that reason, we recommend that CMS consider instituting a hardship exception for such facilities to allow additional time for the transition to the 2015 Edition of CEHRT.**

EHR Reporting Period in 2019 and 2020

AHIMA supports the 90-day reporting period for CY 2019 and CY 2020 as proposed by CMS. We believe the shortened reporting period offers an opportunity for eligible hospitals and CAHs to implement and test the 2015 Edition of CEHRT and provides sufficient time to allow stakeholders to adjust to the proposed scoring methodology and related measures if implemented.

Scoring Methodology for EHs and CAHs Attesting Under the Medicare Promoting Interoperability (PI) Program

AHIMA supports CMS' proposal to adopt a new performance-based scoring methodology with fewer measures and transition away from the current threshold-based methodology in use by the Promoting Interoperability Programs. While the current programs have been critical in advancing electronic health record (EHR) adoption in healthcare, we support CMS' proposal to trim some of the required measures associated with the program while enhancing its focus on interoperability and improving data exchange, access and use. Additionally, we believe the proposed scoring methodology will reduce the current administrative burden associated with the program and offer additional opportunities to eligible hospitals and CAHs to demonstrate success as a meaningful EHR user.

e-Prescribing Objective and Related Measures

AHIMA is concerned with the feasibility of the proposed Query of Prescription Drug Monitoring Program (PDMP) measure. Specifically, a number of our members have expressed concern that their existing EHR is not fully integrated with their state PDMP and therefore lacks the functionality to perform such a query effectively. As a result, to meet the proposed measure, providers must not only log in separately into a PDMP database but manually enter the data into the CEHRT to document completion of the query. Separate sign-in to a non-integrated PDMP also requires hand entry of demographics to search for a specific patient, which increases the probability of erroneously matching a patient to another individual's health information, which in turn raises patient safety concerns. The extra steps and time required to perform such a manual search could result in additional administrative burden, creating a disincentive to query a PDMP.

Furthermore, our members have questioned whether state PDMPs have the necessary infrastructure and resources to manage and sustain the potential increase in queries and data as proposed by the Query of Prescription Drug Monitoring Program measure. Management, oversight, and regulation of PDMPs vary from state to state, as do corresponding budgets and resources. Overtaxing PDMPs as the proposed new measure could do in the absence of a sufficient transition period and resources could jeopardize a PDMP's long-term sustainability.

To ensure successful testing, implementation, and attestation to this measure by eligible hospitals and CAHs, additional time may be needed beyond CY 2019. **AHIMA recommends that CMS consider requiring the Query of Prescription Drug Monitoring Program measure to be optional for CY 2019 and CY 2020.** Allowing such flexibility would enable early adopters of the measure to participate and potentially earn up to five bonus points, while providing additional time for eligible hospitals and CAHs lacking such functionality with their EHRs to improve workflows and prepare for implementation of the measure. Such flexibility would be particularly important for eligible hospitals and CAHs in states that do not allow integration between EHRs and PDMPs to occur. We also believe that ONC should consider adopting standards (provided they are sufficiently mature and successfully tested and piloted) as well as certification criteria to support the query of a PDMP. Such a requirement could encourage vendors to accelerate integration of PDMP data into their products, thereby improving workflows and reducing administrative burden on providers.

AHIMA is also concerned that CMS is not proposing to define an opioid treatment agreement as a standardized electronic document, nor is the agency proposing to define data elements, content structure, or clinical purpose for a document to be deemed a "treatment agreement" under the Verify Opioid Treatment Agreement measure. Our members have expressed concern that a lack of any framework or reference to existing clinical standards would be difficult to operationalize. Because such a requirement would likely require the design of a process and development of a template by vendors and eligible hospitals and CAHs, attestation to this measure would likely be a manual "check the box" process, verifying that the eligible hospital or CAH has sought to identify the existence of a signed opioid treatment agreement and has incorporated it into the CEHRT. Such manual processes may not only increase the opportunity for omission or error of

health data but increase staff workload, creating undue administrative burden for eligible hospitals and CAHs.

Provider to Patient Exchange Objective and Related Measure

AHIMA appreciates CMS' proposed removal of the previously established 50 percent threshold under Stage 3 to reflect the proposed implementation of a performance-based scoring methodology. That said, while we recognize CMS' intent to move away from the current threshold-based methodology, we are concerned that CMS' proposal requiring an eligible hospital or CAH to provide timely access for viewing, downloading, or transmitting a patient's health information for at least one unique patient discharge sets the bar too low for eligible hospitals and CAHs. According to ONC, 52 percent of individuals were offered access to their online medical record by a provider or insurer in 2017.¹ Requiring eligible hospitals and CAHs to provide timely patient access to their electronic health information for at least one unique patient appears incongruent with CMS' intent in the proposed rule to "move beyond the three stages of meaningful use to a new phase of EHR measurement with an increased focus on interoperability and improving patient access to health information."² We recognize the inherent challenges associated with enabling patient access to their electronic health information and in encouraging individuals to access their online medical record, as these are challenges many HIM professionals struggle with every day in their own institutions. However, our members feel strongly that eligible hospitals and CAHs can and should meet a higher threshold than one unique patient under this measure.

Public Health and Clinical Data Registry Reporting Objective and Related Measures

AHIMA supports CMS' proposal to only require attestation to the Syndromic Surveillance Reporting measure and at least one additional measure under the Public Health and Clinical Data objective. We agree with CMS that the proposed changes to the objective and related measures will reduce administrative burden while continuing to support population health monitoring.

Request for Comment – Potential New Measures for HIE Objective: Health Information Exchange Across the Care Continuum

AHIMA appreciates CMS' intent to create additional flexibility for providers and offer a wider range of options in selecting measures that meet a provider's clinical setting, patient population, and clinical practice improvement goals under the Promoting Interoperability Programs. As an organization that represents HIM professionals in more than 40 different employer settings and 120 different job functions, we recognize that the care continuum is broader than existing

¹ ONC Data Brief No. 40. Available at: <https://www.healthit.gov/sites/default/files/page/2018-04/HINTS-2017-Consumer-Data-Brief-april-2018.pdf>.

² *Federal Register* 83, no. 88, May 7, 2018; p.20516. Available at: <https://www.regulations.gov/document?D=CMS-2018-0046-0002>.

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Promoting Interoperability Program participants and increased bi-directional exchange of health information could help facilitate care coordination. Along these lines, AHIMA supports the concept of two additional measure options for the Health Information Exchange objective for eligible hospitals and CAHs as proposed by CMS. Should CMS finalize the proposed measures to involve at least one transition of care or referral and at least one electronic summary of care record, we believe this a reasonable enough bar for stakeholders to adopt as early as 2019. That said, we are cognizant of the fact that there are care settings that struggle with the ability to receive and exchange a patient’s electronic health information compared to Promoting Interoperability Program participants. Therefore, if CMS intends to finalize this measure, we recommend the measure not be increased beyond one transition of care or referral and at least one electronic summary of care record.

Promoting Interoperability Program Future Direction

AHIMA appreciates CMS’s consideration of a set of priority health IT activities that could serve as alternatives to the traditional measures associated with the Promoting Interoperability Programs. Like CMS, we believe demonstrating participation in such related activities could reduce administrative burden while advancing interoperability. Most notably, we believe that participation in the Trusted Exchange Framework and Common Agreement (TEFCA) could serve as a possible health IT activity alternative to meeting the required measures under the Health Information Exchange objective in the Promoting Interoperability Programs. However, given that the TEFCA has neither been finalized nor operationalized, AHIMA is concerned that any intention by CMS to allow such flexibility within the Promoting Interoperability Programs in advance of final implementation of the TEFCA may be premature. Although AHIMA is generally supportive of the TEF, we [raised a number of concerns](#) to ONC related to the draft TEF that we believe should be addressed or greater clarity provided prior to its final implementation. Therefore, we recommend that CMS not finalize this proposed strategy prior to the finalization and implementation of the TEFCA.

We also recognize that not all eligible hospitals and CAHs may be able to immediately participate in such health IT activities. It is unclear from the proposed rule whether CMS proposes to allow demonstration of participation in such health IT activities in lieu of the existing measures or will offer such activities as an alternative method for eligible hospitals and CAHs. We recommend that should CMS proceed with such a strategy that it provide sufficient flexibility within the Promoting Interoperability Programs to allow eligible hospitals and CAHs to choose which methods to pursue, either via demonstration of health IT activities or reporting of traditional measures, to ensure that all eligible hospitals and CAHs have the opportunity to be considered a “meaningful EHR user.”

X. Requirements for Hospitals to Make Public a List of Their Standard Charges via the Internet

AHIMA understands that the Affordable Care Act (ACA) requires each hospital operating within the United States to establish, update, and make public on an annual basis a list of the hospital's standard charges for items and services provided by the hospital, including diagnosis-related groups. We recognize that greater price transparency in healthcare can be a critical data point in helping patients understand their potential financial liability for services obtained at the hospital as well as enabling patients to compare the cost of similar services across different hospitals. That said, we share CMS' concern that chargemaster data may not necessarily be helpful to patients in determining what they are likely to pay for a particular service as a patient's out-of-pocket expenses frequently depend on the rates negotiated between the hospital and insurer. More frequently, our members have noted that the development of the chargemaster is an exercise in ensuring that a hospital's costs may be covered in the long-term versus a true pricing of the hospital's services. Furthermore, recent research suggests that a "systematic relationship" is lacking between higher standard charges and higher quality of care.³ Along these lines, we do not believe that the best measure of a hospital's standard charges is its chargemaster without explaining to consumers why the charges have been set in such a manner and how much the hospital was reimbursed by the insurer. We also believe that patient health literacy is a key element that must be addressed as part of CMS' proposed requirement to assist consumers in understanding the complex nature of the chargemaster and, more generally, pricing in healthcare.

XII. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid- Participating Providers and Suppliers

AHIMA believes that leveraging CMS' health and safety standards required for providers and suppliers participating in the Medicare and Medicaid programs could serve as significant inducement to advance electronic exchange of information between hospitals and providers. We believe that such a requirement could reduce instances of information blocking as defined by the 21st Century Cures Act. That said, we believe that definitions of electronic information to be exchanged need to be standardized further if hospitals and providers are to be able to exchange such information effectively and not be viewed as engaging in practices that constitute information blocking.

³ Batty, Michael, and Benedic Ippolito. "Mystery of the Chargemaster: Examining the Role of Hospital List Prices In What Patients Actually Pay." *Health Affairs* 36, no. 4 (2017): 689 -- 696.

Furthermore, we recommend that, should CMS utilize the Conditions of Participation (CoPs), Conditions for Coverage (CfCs), and Requirements for Participation (RfPs) for Long Term Care to advance electronic information exchange across the care continuum, the requirements not be overly burdensome. We recognize that using CMS' health and safety standards could provide sufficient motivation to providers and suppliers to demand that their EHR vendors offer the necessary functionalities to advance electronic information exchange. That said, we want to ensure that providers and suppliers are not faced with having to meet standards that cannot be executed, either because their vendor lacks such functionalities or because the providers or suppliers lacks the necessary resources to execute the standards.

As previously shared in our [comments](#) to CMS in 2016 in response to its proposed rule, 81 FR 39448, AHIMA also supports CMS' clarification that "a patient has the right to access their medical records, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual" However, we continued to be concerned that the language "within a reasonable time frame" in the proposed rule creates ambiguity as to the period in which a hospital must provide a patient with a copy of their medical records. **We recommend that the proposed rule be revised at §482.13(d)(2) to state that a patient's request to access their medical record must be fulfilled within the time frame set forth under HIPAA.** Such specificity would align §482.13(d)(2) with 45 CFR 164.524(b)(2) and the [February 2016 OCR guidance](#), and eliminate uncertainty as to the period in which a hospital must provide patient access to medical records under the conditions of participation (CoP). As a member of the GetMyHealthData campaign, AHIMA has long advocated that consumers' access to their health information is essential to improved health and healthcare, and we will continue to support efforts to clarify an individual's right to access their health information.

In addition, we are cognizant that not all care settings, including LTPAC facilities, behavioral health facilities, and home health agencies, are as advanced in exchanging electronic health information as institutions eligible for the Promoting Interoperability Programs. **For that reason, we suggest that under new or revised CoPs/CfCs/RfPs, a transition period or delayed implementation date is needed, at least until CY 2021, to allow such facilities to catch-up. In the interim, we recommend that the proposed new or revised CoPs/CfCs/RfPs allow for non-electronic forms of sharing medically necessary information be permitted to continue in instances where the receiving provider, supplier or patient/resident cannot receive the information electronically.**

Conclusion

AHIMA appreciates the opportunity to comment on the proposed modifications to the Medicare Hospital IPPS program for FY 2019. AHIMA is committed to working with CMS and the

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healthcare industry to improve the quality of healthcare data for reimbursement, quality reporting, and other applied analytics.

If AHIMA can provide any further information, or if there are any questions regarding this letter and its recommendations, please contact Sue Bowman, Senior Director of Coding Policy and Compliance, at (312) 233-1115 or sue.bowman@ahima.org.

Sincerely,

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

Dr. Wylecia Wiggs Harris, PhD, CAE
Chief Executive Officer