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July 7, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1735-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 2021 rates, as published in the May 29, 2020, issue of the *Federal Register* (CMS-1735-P).

AHIMA is a global nonprofit association of health information management (HIM) 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 HIM 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.

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

II. PROPOSED CHANGES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (85FR32470)

II-D – Proposed Changes to Specific MS-DRG Classifications (85FR32471)

When analyzing FY 2020 MedPAR claims data and proposing MS-DRG changes for FY 2022, CMS should consider the impact on this data of elective surgery cancellations and declines in hospital admissions for other non-emergent care during the COVID-19 pandemic.

II-D-2a – Pre-MDC: Bone Marrow Transplants (85FR32473)

AHIMA urges CMS to re-evaluate the O.R./non-O.R. procedure designation status for bone marrow transplants as part of the planned comprehensive, systematic review of the ICD-10-

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PCS procedure codes and the process for determining when a procedure is considered an operating room procedure. We agree with CMS that bone marrow transplant procedures are medical procedures and do not utilize the resources of an operating room. We also agree that all ICD-10-PCS procedure codes for bone marrow transplants should have the same O.R./non-O.R. procedure designation. However, we believe bone marrow transplants represent an example of why the current process of determining whether a procedure qualifies for designation as an O.R. procedure may be outdated. As CMS stated in section II.D.11. of the proposed rule, while procedures have typically been evaluated on the basis of whether they would be performed in an operating room, there may be other factors to consider with regard to resource consumption. Bone marrow transplants are a major medical procedure, utilize significant resources, and pose risks of serious complications.

Based on CMS' data analysis, we support retaining the current structure of MS-DRG 014 (Allogeneic Bone Marrow Transplant) rather than creating a two-way severity split.

II-D-2b – Pre-MDC: Chimeric Antigen Receptor (CAR) T-Cell Therapies (85FR32475)

We support the creation of a new MS-DRG for chimeric antigen receptor (CAR) T-cell immunotherapy. We agree that CAR T-cell therapies are clinically different from other cases that group to the MS-DRG where these therapies are currently classified (MS-DRG 016, Autologous Bone Marrow Transplant with CC/MCC or T-Cell Immunotherapy).

In addition to the two existing codes for CAR T-cell therapies, we recommend that the new codes for CAR T-cell therapies going into effect on October 1 (brexucabtagene autoleucel immunotherapy and lisocabtagene maraleucel immunotherapy) also be classified to new MS-DRG 018 (Chimeric Antigen Receptor (CAR) T-cell Immunotherapy).

II-D-3a – MDC 1 (Diseases and Disorders of the Nervous System): Carotid Artery Stent Procedures (85FR32476)

AHIMA supports the reassignment of ICD-10-PCS procedure codes describing dilation of a carotid artery with an intraluminal device to MS-DRGs 034, 035, and 036 (Carotid Artery Stent Procedures with MCC, with CC, and without CC/MCC, respectively) to ensure consistent MS-DRG classification of procedures involving dilation of a carotid artery with intraluminal device.

II-D-3b – MDC 1 (Diseases and Disorders of the Nervous System): Epilepsy with Neurostimulator (85FR32481)

We agree with CMS that cases describing a neurostimulator generator inserted into the skull with the insertion of a neurostimulator lead into the brain should not be reassigned from 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) to MS-DRG 021 (Intracranial Vascular Procedures with PDX Hemorrhage

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with CC). Neurostimulator insertion for the treatment of epilepsy is not clinically similar to treatment of intracranial hemorrhage.

II-D-4 – MDC 3 (Diseases and Disorders of Ear, Nose, and Throat): Temporomandibular Joint Replacements (85FR32484)

Although we agree that deleting MS-DRGs 129-134 and creating six new MS-DRGs seems appropriate, **we recommend that CMS re-evaluate the list of ICD-10-PCS procedure codes proposed for reassignment to new MS-DRGs 140-145.**

CMS has proposed removing a number of ICD-10-PCS procedure codes from the MDC 3 logic that had been inadvertently included as a result of replication during the transition from ICD-9- to ICD-10-based MS-DRGs. However, **there are additional procedure codes not included on CMS' list shown in table 6P.2c that should also be removed from MDC 3 logic.** For example, while some codes for procedures on the esophagus have been proposed for removal from the MDC 3 logic, other procedures performed on the esophagus are still included in the GROUPER logic. Also, procedures performed on the heart, carotid artery, chest, back abdomen, buttock, liver, and leg are not ear, nose, mouth, or throat procedures, but they are included in the GROUPER logic for MS-DRGs 143-145 (Other Ear, Nose, Mouth And Throat O.R. Procedures with MCC, with CC, and without CC/MCC, respectively). Procedures on the chest, back, and abdomen are not head or neck procedures, but they are included in the GROUPER logic for MS-DRGs 140-142 (Major Head and Neck Procedures with MCC, with CC, and without CC/MCC, respectively). Also, while CMS proposed reassigning code 0WJ10ZZ (Inspection of cranial cavity, open approach) from MDC 3 to MDC 1 (Diseases and Disorders of the Nervous System), codes for other procedures performed on the cranial cavity are included in the GROUPER logic for MS-DRGs 140-142.

We recommend that CMS review the procedure codes listed in tables 6P.2a and 6P.2b to identify all of the procedure codes that should be removed from the GROUPER logic for proposed new MS-DRGs 140-145.

CMS should also consider whether proposed new MS-DRGs 140-142 (Major Head and Neck Procedures with MCC, with CC, and without CC/MCC, respectively) belong in MDC 3 or whether the title of MDC should be changed. The MDC 3 description “Diseases and Disorders of Ear, Nose and Throat” covers a more limited set of anatomic sites than the “major head and neck procedures” included in MS-DRGs 140-142.

II-D-5a – MDC 5 (Diseases and Disorders of the Circulatory System): Left Atrial Appendage Closure (LAAC) (85FR32490)

AHIMA supports the reassignment of procedure codes describing left atrial appendage closure via an open approach from MS-DRGs 250 and 251 (Percutaneous Cardiovascular Procedures without Coronary Artery Stent with and without MCC, respectively) to MS-DRGs 273 and 274 (Percutaneous Intracardiac Procedures with and without MCC, respectively).

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II-D-5b – MDC 5 (Diseases and Disorders of the Circulatory System): Endovascular Cardiac Valve Replacement and Supplement Procedures (85FR32495)

Based on CMS' data analysis, we agree with retaining the current structure of MS-DRGs 266 and 267 (Endovascular Cardiac Valve Replacement and Supplement Procedures with and without MCC, respectively).

II-D-5c – MDC 5 (Diseases and Disorders of the Circulatory System): Insertion of Cardiac Contractility Modulation Device (85FR32496)

We support the proposed addition of 24 procedure code combinations to MS-DRGs 222-227 (Cardiac Defibrillator Implant with and without Cardiac Catheterization with and without AMI/HF/Shock with and without MCC, respectively) and the deletion of clinically invalid procedure code combinations from the logic for these MS-DRGs.

II-D-6 – MDC 6 (Diseases and Disorders of the Digestive System): Acute Appendicitis (85FR32500)

We support CMS' proposal not to reassign diagnosis code K35.20, Acute appendicitis with generalized peritonitis, without abscess, to MS-DRGs 338, 339, and 340 (Appendectomy with Complicated Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively), and to reassign diagnosis code K35.32, Acute appendicitis with perforation and localized peritonitis, without abscess, to MS-DRGs 341, 342, and 343 (Appendectomy without Complicated Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively). We agree that if the presence of an abscess clinically determines whether a diagnosis of acute appendicitis would be considered a complicated principal diagnosis, then all diagnosis codes for acute appendicitis without abscess should be assigned to MS-DRGs 341, 342, and 343 for consistency.

II-D-7a – MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Cervical Radiculopathy (85FR32503)

AHIMA agrees with maintaining the current assignment of diagnosis codes describing cervical radiculopathy in MDC 1 until further analysis of whether all the diagnosis codes describing radiculopathy of a specified or unspecified site should be assigned to the same MDC, and if so, whether those codes should be assigned to MDC 1 or MDC 8. We also agree with CMS' plan to solicit clinical input from medical specialty societies on the appropriate MDC classification for the diagnosis codes describing radiculopathy.

II-D-7b – MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Hip and Knee Replacements (85FR32505)

We support the establishment of new MS-DRGs for hip replacement with a principal diagnosis of hip fracture (regardless of the type of bearing surface implant used in the joint replacement procedure).

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II-D-8a – MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract): Kidney Transplants (85FR32510)

We support the proposed modification of the GROUPER logic for MS-DRG 652 (Kidney Transplant) by allowing the presence of a procedure code describing transplantation of the kidney to determine the MS-DRG assignment independent of the MDC of the principal diagnosis except in the case of MDC 24 (Multiple Significant Trauma) or MDC 25 (Human Immunodeficiency Virus Infections).

We agree that CMS should consider having the resource-intensive procedures currently assigned to the Pre-MDC MS-DRGs determine assignment to MS-DRGs within the clinically appropriate MDC, and thus ultimately perhaps be able to eliminate the Pre-MDC category entirely.

AHIMA also supports the creation of new MS-DRGs 019 (Simultaneous Pancreas/Kidney Transplant with Hemodialysis), 650 (Kidney Transplant with Hemodialysis with MCC), and 651 (Kidney Transplant with Hemodialysis without MCC).

II-D-8b – MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract): Proposed Addition of Diagnoses to Other Kidney and Urinary Tract Procedures Logic (85FR32519)

We agree with CMS' proposal not to add the requested ICD-10-CM to MS-DRGs 673, 674, and 675 (Other Kidney and Urinary Tract Procedures with MCC, with CC, and without CC/MCC, respectively) when reported with procedure codes describing the insertion of totally implantable vascular access devices (TIVADs) and tunneled vascular access devices. As stated by CMS in its rationale, these devices may be inserted for a variety of diagnoses, and adding diagnosis codes that are not specific to renal failure would not maintain clinical coherence with other cases in these MS-DRGs.

AHIMA supports the reassignment of diagnosis codes describing a mechanical complication of a vascular access catheter to MS-DRGs 673, 674, and 675 (Other Kidney and Urinary Tract Procedures with MCC, with CC, and without CC/MCC, respectively) and 698, 699, and 700 (Other Kidney and Urinary Tract Diagnoses with MCC, with CC, and without CC/MCC, respectively) in MDC 11.

We also support adding ICD-10-CM diabetes codes E09.22, E10.22, E11.22, and E13.22 to the special logic in MS-DRGs 673, 674, and 675, when these codes are reported with a secondary diagnosis code of either N18.5, Chronic kidney disease, stage 5, or N18.6, End stage renal disease, since these diagnosis code combinations describe an indication that could require the insertion of a totally implantable vascular access device or a tunneled vascular access device for hemodialysis purposes. CMS is correct that the official coding guidelines instruct to sequence codes for diabetes with diabetic chronic kidney disease before the codes describing the stage of the kidney disease.

We agree with the proposed addition of ICD-10-CM codes for complications of kidney transplant to the list of principal diagnosis codes in the subset of GROUPER logic in MS-DRGs 673, 674, and

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675 that recognizes the insertion of totally implantable vascular access devices or tunneled vascular access devices as an inpatient procedure for the purposes of hemodialysis.

We agree that seven ICD-10-CM codes that do not describe renal failure or indications that would generally require the insertion of totally implantable vascular access devices—or tunneled vascular access devices for the purpose of hemodialysis—should be removed from the special logic in MS-DRGs 673, 674, and 675.

II-D-9 – MDC 17 (Myeloproliferative Diseases and Disorders, Poorly Differentiated Neoplasms): Inferior Vena Cava Filter Procedures (85FR32524)

AHIMA agrees that ICD-10-PCS procedure codes 06H00DZ, 06H03DZ, and 06H04DZ describing the insertion of an intraluminal device into the inferior vena cava should be designated as non-O.R. procedures since these procedures are not surgical in nature, and related ICD-10-PCS codes are currently designated as non-O.R. procedures.

We recommend that CMS remove code Z08 from the GROUPER logic for MS-DRGs 837, 838, and 839. The GROUPER logic for MS-DRGs 837 (Chemotherapy with Acute Leukemia as Secondary Diagnosis or with High Dose Chemotherapy Agent with MCC), 838 (Chemotherapy with Acute Leukemia as Secondary Diagnosis with CC or High Dose Chemotherapy Agent), and 839 (Chemotherapy with Acute Leukemia as Secondary Diagnosis without CC/MCC) is defined by a principal diagnosis of chemotherapy identified with ICD-10-CM diagnosis codes Z08, Encounter for follow-up examination after completed treatment for malignant neoplasm, Z51.11, Encounter for antineoplastic chemotherapy, or Z51.112, Encounter for antineoplastic immunotherapy, along with a secondary diagnosis of acute leukemia or a procedure code for the introduction of a high dose chemotherapy agent. ICD-10-CM code Z08 identifies a follow-up visit after completed treatment for a malignant neoplasm. As stated in the ICD-10-CM Official Guidelines for Coding and Reporting, follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. Therefore, ICD-10-CM code Z08 does not describe an admission for chemotherapy. Also, code Z08 is on the Unacceptable Principal diagnosis edit code list.

II-D-10a– Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989: Horseshoe Abscess with Drainage (85FR32527)

We support adding ICD-10-PCS procedure code 0J9B0ZZ, Drainage of perineum subcutaneous tissue and fascia, open approach, to MS-DRGs 356, 357, and 358 (Other Digestive System O.R. Procedures with MCC, with CC, and without CC/MCC, respectively) in MDC 6, since this procedure may be performed for a horseshoe abscess (ICD-10-CM code K61.31).

II-D-10b– Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989: Chest Wall Deformity with Supplementation (85FR32527)

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We support adding two ICD-10-PCS codes describing procedures to supplement or reinforce the chest wall with biologic or synthetic material to MS-DRGs 515, 516, and 517 (Other Musculoskeletal System and Connective Tissue O.R. Procedures, with MCC, with CC, and without CC/MCC, respectively) in MDC 8. This would improve clinical consistency since one of the codes describing these procedures is already assigned to MDC 8. As stated in the proposed rule, these procedures may be performed for acquired deformity of chest and rib (ICD-10-CM diagnosis code M95.4).

II-D-10c– Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989: Hepatic Malignancy with Hepatic Artery Embolization (85FR32528)

AHIMA supports adding ICD-10-PCS procedure codes 04V33DZ, Restriction of hepatic artery with intraluminal device, percutaneous approach, and 04L33DZ, Occlusion of hepatic artery with intraluminal device, percutaneous approach, to MS-DRGs 423, 424 and 425 (Other Hepatobiliary or Pancreas Procedures with MCC, with CC, and without CC/MCC, respectively) in MDC 7 (Diseases and Disorders of the Hepatobiliary System and Pancreas).

II-D-10d– Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989: Hemoptysis with Percutaneous Artery Embolization (85FR32530)

We support adding ICD-10-PCS procedure codes describing embolization of an upper artery with an intraluminal device to MS-DRGs 166, 167, and 168 (Other Respiratory System O.R. Procedures with MCC, with CC and without CC/MCC, respectively) in MDC 4 (Diseases and Disorders of the Respiratory System).

II-D-10e– Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989: Acquired Coagulation Factor Deficiency with Percutaneous Artery Embolization (85FR32531)

We agree with CMS' proposal not to reassign ICD-10-CM diagnosis code D68.4, Acquired coagulation factor deficiency, from MDC 16 (Diseases and Disorders of Blood, Blood Forming Organs, Immunologic Disorders) to MDC 5 (Diseases and Disorders of the Circulatory System). As stated by CMS in the proposed rule, a diagnosis of an acquired bleeding disorder is not comparable to conditions described by the ICD-10-CM code R58, Hemorrhage, not elsewhere classified, and ICD-10-CM code D68.4 is most clinically aligned with the diagnosis codes in MDC 16.

II-D-10f– Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989: Epistaxis with Percutaneous Artery Embolization (85FR32533)

AHIMA supports adding ICD-10-PCS procedure codes 03LM3DZ, Occlusion of right external carotid artery with intraluminal device, percutaneous approach, 03LN3DZ, Occlusion of left external carotid artery with intraluminal device, percutaneous approach, and 03LR3DZ, Occlusion of face artery with intraluminal device, percutaneous approach, to proposed new MS-DRGs 143, 144, and 145 (Other Ear, Nose, Mouth and Throat O.R. Procedures with MCC, with CC, and

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without CC/MCC, respectively) in MDC 3 (Disease and Disorders of the Ear, Nose, Mouth and Throat).

II-D-10g– Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989: Revision or Removal of Synthetic Substitute in Peritoneal Cavity (85FR32535)

We agree that ICD-10-PCS procedure codes describing revision or removal of synthetic substitute in the peritoneal cavity are related to the principal diagnosis codes describing complications of intracranial shunts, and so it is appropriate for the procedures to group to the same MS-DRGs as the principal diagnoses describing complications of intracranial shunts. Therefore, we support the addition of these procedure codes to MS-DRGs 031, 032, and 033 (Ventricular Shunt Procedures with MCC, with CC, and without CC/MCC, respectively) in MDC 1 (Diseases and Disorders of the Nervous System).

II-D-10h– Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989: Revision of Totally Implantable Vascular Access Devices (85FR32536)

We support the addition of ICD-10-PCS procedure codes describing insertion of totally implantable vascular access devices to the MS-DRGs describing “Other” procedures within MDCs 4, 6, 7, 8, 13, and 16.

II-D-10i– Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989: Multiple Trauma With Internal Fixation of Joints (85FR32538)

AHIMA supports the addition of 161 ICD-10-PCS procedure codes describing internal fixation of upper and lower joints to MS-DRGs 957, 958, and 959 (Other O.R. Procedures for Multiple Significant Trauma with MCC, with CC, and without CC/MCC, respectively) in MDC 24 (Multiple Significant Trauma).

We agree that a more comprehensive analysis of the diagnoses and procedures assigned to MDC 24 should be undertaken.

II-D-10j– Review of Procedure Codes in MS-DRGs 981 Through 983 and 987 Through 989: Reassignment of Procedures among MS-DRGs 981 through 983 and 987 through 989 (85FR32540)

We support the proposed reassignment of three procedure codes from MS-DRGs 981, 982, and 983 (Extensive O.R. Procedure Unrelated to Principal Diagnosis with MCC, with CC, without CC/MCC, respectively) to MS-DRGs 987, 988, and 989 (Non-Extensive Procedure Unrelated to Principal Diagnosis with MCC, with CC, and without CC/MCC, respectively) and the reassignment of three procedure codes from MS-DRGs 987, 988, and 989 to MS-DRGs 981, 982, and 983.

II-D-11a – Operating Room (O.R.) and Non-O.R. Issues: Background (85FR32542)

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We appreciate CMS' plan to conduct a comprehensive, systematic review of the ICD-10-PCS procedure codes, including a review of the process for determining when a procedure is considered an operating room procedure. We believe this review is timely in light of the increased level of detail in coded data since the transition to ICD-10-PCS, as well as changes in medical practice. We believe there are other important factors besides the use of an operating room to consider when assigning the O.R./non-O.R. procedure designation. Due to medical and technological advances, complex and resource-intensive procedures may not always be performed in an operating room.

Caution should be used when analyzing FY 2020 MedPAR data, as procedural data will not be representative of the typical procedures performed in an inpatient hospital setting due to the cancellation of elective surgeries during the COVID-19 pandemic.

II-D-11b(1) – Operating Room (O.R.) and Non-O.R. Issues: O.R. Procedures to Non-O.R. Procedures - Endoscopic Revision of Feeding Devices (85FR32544)

AHIMA supports changing the designation of three ICD-10-PCS procedure codes that describe endoscopic revision of feeding devices from an O.R. procedure to a non-O.R. procedure.

II-D-11c(1) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures - Percutaneous/Endoscopic Biopsy of Mediastinum (85FR32544)

We support changing the designation of two ICD-10-PCS procedure codes that describe percutaneous and percutaneous endoscopic biopsy of the mediastinum from a non-O.R. procedure to an O.R. procedure.

We also support reassigning procedure codes 0WBC0ZZ, Excision of mediastinum, open approach, 0WBC3ZZ, Excision of mediastinum, percutaneous approach, and 0WBC4ZZ, Excision of mediastinum, percutaneous endoscopic approach, from MS-DRGs 163, 164, and 165 (Major Chest Procedures with MCC, with CC, and without CC/MCC, respectively) to MS-DRGs 166, 167 and 168 (Other Respiratory System O.R. Procedures with MCC, with CC, and without CC/MCC, respectively).

II-D-11c(2) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures - Percutaneous Endoscopic Chemical Pleurodesis (85FR32545)

We support changing the designation of ICD-10-PCS procedure code 3E0L4GC, Introduction of other therapeutic substance into pleural cavity, percutaneous endoscopic approach, from a non-O.R. procedure to an O.R. procedure. As CMS stated in the proposed rule, the approach value "4" Percutaneous Endoscopic was added to the root operation Introduction table 3E0, to capture percutaneous endoscopic administration of a therapeutic substance. This indeed makes code 0BJQ4ZZ, Inspection of pleura, percutaneous endoscopic approach, no longer necessary as an additional code to capture the endoscopic component of the procedure. Since code 3E0L4GC is now reported alone for thoracoscopic chemical pleurodesis, we agree this code should be designated as an O.R. procedure.

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II-D-11c(3) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures - Percutaneous Endoscopic Excision of Stomach (85FR32546)

AHIMA supports changing the designation of ICD-10-PCS procedure codes 0DB64ZZ, Excision of stomach, percutaneous endoscopic approach, and code 0DB64ZX, Excision of stomach, percutaneous endoscopic approach, diagnostic, from a non-O.R. procedure to an O.R. procedure.

We agree that diagnoses assigned to MDC 5 (Diseases and Disorders of the Circulatory System), MDC 21 (Injuries, Poisonings and Toxic Effects of Drugs), and MDC 24 (Multiple Significant Trauma) are not typically corrected surgically by percutaneous endoscopic vertical (sleeve) gastrectomy, and that procedure codes describing the percutaneous endoscopic excision of stomach should all be assigned to the same MDCs. Therefore, we support removing ICD-10-PCS procedure code 0DB64Z3, Excision of stomach, percutaneous endoscopic approach, vertical (sleeve), from MDCs 5, 21, and 24.

We **do not support** changing the designation of ICD-10-PCS procedure codes for excision of stomach, percutaneous approach (0DB63Z3, 0DB63ZZ) from an O.R. procedure to a non-O.R. procedure. These procedures are similar to the codes for excision of stomach, percutaneous endoscopic approach, that are being proposed to be designated as O.R. procedures. We believe the codes describing excision of stomach via percutaneous and percutaneous endoscopic approaches should have the same O.R. procedure designation.

II-D-11c(4) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures - Percutaneous Endoscopic Drainage (85FR32547)

We agree that all ICD-10-PCS procedure codes describing procedures involving laparoscopic drainage of peritoneum, peritoneal cavity, and gallbladder should be designated as O.R. procedures.

We also agree that procedure codes for drainage of the gallbladder should be assigned to the same MDC.

We support designating as non-extensive O.R. procedures nine ICD-10-PCS codes describing drainage of the peritoneum, peritoneal cavity, or gallbladder that are currently classified as extensive O.R. procedures.

II-D-11c(5) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Control of Bleeding (85FR32548)

AHIMA agrees with the proposed redesignation of ICD-10-PCS procedure code 0W3G0ZZ, Control bleeding in peritoneal cavity, open approach, as an O.R. procedure, as this would be consistent with similar procedure codes describing control of bleeding in other anatomic sites.

II-D-11c(6) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Inspection of Penis (85FR32549)

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We support changing the designation of ICD-10-PCS procedure code 0VJS0ZZ, Inspection of penis, open approach, from a non-O.R. procedure to an O.R. procedure.

II-D-12c – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2021: Guiding Principles for Making Changes to Severity Levels (85FR32550)

AHIMA acknowledges and appreciates CMS’ recognition that the transition to ICD-10-CM and the significant changes that have occurred to diagnosis codes since the FY 2008 review warrants a comprehensive CC/MCC analysis.

We appreciate CMS’ efforts to update the process of determining severity levels – a task that is both complex and challenging. However, we are concerned that the guiding principles identified by the CMS workgroup as meaningful indicators of expected resource use by a secondary diagnosis are subjective and may be difficult to apply consistently. For example, “impedes patient cooperation and/or management of care,” “serves as a marker for advanced disease states across multiple different comorbid conditions,” and “involves a chronic illness with susceptibility to exacerbations or abrupt decline” are open to interpretation or differences in clinical opinion. The guiding principles do not provide clear logic for decision-making. They also appear to be more applicable to MCC conditions than CC conditions. It is also not clear how these guiding principles will be used in conjunction with mathematical analysis of claims data to make decisions about severity levels. Will a condition need to meet both the guiding principles and the mathematical criteria in order to be designated as a CC or MCC?

We urge CMS to consider revising the guiding principles such that they can be applied across all diagnosis codes in a clear, objective, and consistent manner.

We also recommend that CMS convene a technical advisory panel comprised of industry stakeholders and subject matter experts (including clinicians and health information professionals) to review the guiding principles and assess the practical application across ICD-10-CM diagnosis codes for determination of severity designations of MCC/CC.

II-D-12d – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2021: Proposed Additions and Deletions to the Diagnosis Code Severity Levels for FY 2021 (85FR32550)

We agree with the proposed additions and deletions to the MCC and CC lists as shown in tables 6I.1, 6I.2, 6J.1 and 6J.2.

AHIMA requests that CMS review the new ICD-10-CM diagnosis codes for cytokine release syndrome (CRS) that will become effective October 1, 2020, and determine if the codes representing the higher CRS grades should be designated as a CC or MCC. According to the

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American Society for Transplantation and Cellular Therapy (ASTCT) CRS grading definitions¹, CRS grades 3, 4, and 5 involve patients requiring acute hospital intervention to prevent further deterioration and would appear to qualify for CC/MCC designation.

II-D-12e – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2021: Proposed CC Exclusions List for FY 2021 (85FR32550)

We agree that a secondary diagnosis of stroke should not be excluded from acting as an MCC when reported with a principal diagnosis of diabetes.

We support the proposed additions and deletions to the CC Exclusions List as shown in tables 6G.1, 6G.2, 6H.1, and 6H.2.

II-D-14a(1) – Proposed Changes to the Medicare Code Editor (MCE): Age Conflict Edit – Maternity Diagnoses (85FR32552)

AHIMA supports the proposed changes to the Maternity diagnoses category code list under the Age Conflict edit as a result of new ICD-10-CM diagnosis codes going into effect on October 1.

II-D-14a(2) – Proposed Changes to the Medicare Code Editor (MCE): Age Conflict Edit – Adult Diagnoses (85FR32552)

We support the proposed addition of new ICD-10-CM diagnosis codes for age-related osteoporosis to the Adult diagnoses category list under the Age Conflict edit.

II-D-14b(1) – Proposed Changes to the Medicare Code Editor (MCE): Sex Conflict Edit – Diagnoses for Females Only (85FR32553)

We support the proposed changes to the edit code list for the Diagnoses for Females Only edit as a result of new ICD-10-CM diagnosis codes.

II-D-14b(2) – Proposed Changes to the Medicare Code Editor (MCE): Sex Conflict Edit – Procedures for Females Only (85FR32553)

We support the proposed addition of new ICD-10-PCS procedure codes for low dose rate (LDR) brachytherapy to the edit code list for the Procedures for Females Only edit.

II-D-14b(3) – Proposed Changes to the Medicare Code Editor (MCE): Sex Conflict Edit – Procedures for Males Only (85FR32553)

¹ Lee, David W. et al, "ASTCT Consensus Grading For Cytokine Release Syndrome and Neurologic Toxicity Associated with Immune Effector Cells". *Biology Of Blood and Marrow Transplantation*, vol. 25, no. 4, 2019, pp. 625-638.
<https://www.sciencedirect.com/science/article/pii/S1083879118316914>

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We support the proposed addition of new ICD-10-PCS procedure codes for low dose rate (LDR) brachytherapy to the edit code list for the Procedures for Males Only edit.

II-D-14c – Proposed Changes to the Medicare Code Editor (MCE): Manifestation Code as Principal Diagnosis Edit (85FR32554)

We support the proposed addition of new ICD-10-CM diagnosis codes representing manifestation codes that cannot be sequenced first per ICD-10-CM coding conventions to the edit code list for the Manifestation Codes Not Allowed as Principal Diagnosis edit. We also support deleting codes that will no longer be valid on October 1 from this edit code list.

II-D-14d – Proposed Changes to the Medicare Code Editor (MCE): Unacceptable Principal Diagnosis Edit (85FR32554)

We support the proposed changes to the Unacceptable Principal Diagnosis edit code list as a result of new ICD-10-CM diagnosis codes. These new codes cannot be sequenced first per ICD-10-CM coding conventions.

II-D-15 – Proposed Changes to Surgical Hierarchies (85FR32556)

AHIMA supports the proposed revision to the surgical hierarchies for the Pre-MDC MS-DRGs, and MDCs 3, 8, and 11.

II-G – Proposed Add-On Payments for New Services and Technologies for FY 2021 (85FR32568)

AHIMA recommends that CMS explore options other than creating codes in section X of ICD-10-PCS when it is necessary to uniquely identify drugs, devices, or laboratory tests for the purpose of administering a new technology add-on payment (NTAP). Potential alternative options include National Drug Codes (NDCs) and/or HCPCS level 2 codes. We continue to believe that it is not appropriate to create codes in ICD-10-PCS for procedures and services that would not typically be coded in a hospital inpatient setting.

VIII. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS (85FR32830)

VIII-D – Proposed Changes to the Medicare and Medicaid Promoting Interoperability Programs (85FR32852)

AHIMA appreciates CMS' focus on improving nationwide interoperability as well as continued flexibility, particularly in light of the ongoing public health emergency. We offer the following comments related to the proposed changes to the Promoting Interoperability Programs.

Seema Verma

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EHR Reporting Period for CY 2022

AHIMA supports the 90-day reporting period for CY 2022 for new and returning participants in the Medicare Promoting Interoperability Program as proposed by CMS. We agree with CMS that the shortened reporting period offers important programmatic consistency for hospital reporting in CY 2022.

Proposed Changes to Query of Prescription Drug Monitoring Program under the Electronic Prescribing Objective

AHIMA shares CMS' concern that the Prescription Drug Monitoring Program (PDMP) queries are not fully integrated into existing health IT systems and workflows, requiring providers to log separately into PDMP databases and manually enter the data into the CEHRT to document completion of the query. Our members are also concerned that separate sign-in to a non-integrated PDMP requires hand entry of demographic data elements to search for a specific patient, which may increase the probability of erroneously matching a patient to another individual's health information, which in turn raises patient safety concerns. For that reason, we support CMS' proposal to maintain the Query of PDMP measure as optional in CY 2021.

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