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June 20, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: **CMS-1716-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 2020 rates, as published in the May 3, 2019, issue of the *Federal Register* (CMS-1716-P).

AHIMA is the national nonprofit association of health information management (HIM) professionals. Serving 52 affiliated component state associations including the District of Columbia and Puerto Rico, AHIMA represents more than 103,000 HIM professionals dedicated to promoting and advocating for best practices and effective standards in health information. AHIMA's credentialed and certified HIM members can be found in more than 40 different employer settings in 120 diverse job functions—consistently ensuring that health information is accurate, timely, complete, and available to patients and providers. AHIMA provides leadership through education and workforce development, as well as thought leadership in continuing HIM research and applied management for health information.

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 (84FR19170)

II-F – Proposed Changes to Specific MS-DRG Classifications (84FR19171)

II-F-2a – Pre-MDC: Peripheral ECMO (84FR19172)

AHIMA supports the reassignment of ICD-10-PCS codes for peripheral ECMO procedures to MS-DRG 003 (ECMO or Tracheostomy with Mechanical Ventilation > 96 Hours or Principal Diagnosis Except Face, Mouth and Neck with Major O.R. Procedure).

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II-F-2b – Pre-MDC: Allogeneic Bone Marrow Transplant (84FR19176)

We agree with the reassignment of four procedure codes for autologous hematopoietic cell transplant to MS-DRGs 016 and 017 (Autologous Bone Marrow Transplant with CC/MCC or T-cell Immunotherapy and Autologous Bone Marrow Transplant without CC/MCC, respectively).

We also support retaining the current structure of MS-DRG 014 (Allogeneic Bone Marrow Transplant).

II-F-3 – MDC 1 (Diseases and Disorders of the Nervous System): Carotid Artery Stent Procedures (84FR19182)

AHIMA agrees with the proposed modifications to MS-DRGs 034-036 (Carotid Artery Stent Procedures with MCC, with CC, and without CC/MCC, respectively) 037-039 (Extracranial Procedures with MCC, with CC, and without CC/MCC, respectively). All procedures involving dilation of a carotid artery with insertion of an intraluminal device should be classified to MS-DRGs 034-036, and procedures that don't involve the carotid artery and an intraluminal device should be removed from these MS-DRGs.

II-F-4 – MDC 4 (Diseases and Disorders of the Respiratory System): Pulmonary Embolism (84FR19185)

We support the reassignment of three diagnosis codes for pulmonary embolism with acute cor pulmonale to MS-DRG 175 and to revise the title accordingly (Pulmonary Embolism with MCC or Acute Cor Pulmonale).

II-F-5a – MDC 5 (Diseases and Disorders of the Circulatory System): Transcatheter Mitral Valve Repair with Implant (84FR19185)

We support the reassignment of procedure codes describing a transcatheter cardiac valve procedure (supplement procedure) to MS-DRGs 266 and 267 and revising the titles accordingly (Endovascular Cardiac Valve Replacement and Supplement Procedures with MCC and Endovascular Cardiac Valve Replacement and Supplement Procedures without MCC, respectively).

We also support creation of two new MS-DRGs 319 (Other Endovascular Cardiac Valve Procedures with MCC) and 320 (Other Endovascular Cardiac Valve Procedures without MCC).

II-F-5b – MDC 5 (Diseases and Disorders of the Circulatory System): Revision of Pacemaker Lead (84FR19193)

We agree that ICD-10-PCS procedure code 02H60JZ, Insertion of pacemaker lead into right atrium, open approach, should be added to the list of non-O.R. procedures that impact MS-DRGs 260, 261, and 262 (Cardiac Pacemaker Revision Except Device Replacement with MCC, with

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CC, and without CC/MCC, respectively) when reported as a stand-alone procedure code, in order to be consistent with other procedure codes describing insertion of pacemaker lead into atrium.

II-F-6a – MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Knee Procedures with Principal Diagnosis of Infection (84FR19193)

While we agree with the proposed addition of ICD-10-CM diagnosis code M00.9, Pyogenic arthritis, unspecified, to the list of principal diagnoses for MS-DRGs 485, 486, and 487 (Knee Procedure with Principal Diagnosis of Infection with MCC, with CC, and without CC/MCC, respectively), we **disagree** with not also adding code A54.42, Gonococcal arthritis, to these MS-DRGs. Neither code M00.9 nor code A54.42 specifically includes the knee in the code title. However, both codes apply to the conditions described in the code titles when they occur in any joint, including the knee. Also, the DRG logic requires a principal diagnosis code in combination with an ICD-10-PCS code for a knee procedure.

Since code A54.42 is the appropriate code for gonococcal arthritis of the knee (regardless of whether there are specific Index entries for this anatomic site), we believe it should be added to MS-DRGs 485-487 along with code M00.9. As stated above, the ICD-10-PCS code will identify the knee as the anatomic site.

We support the removal of several ICD-10-CM diagnosis codes from the list of principal diagnosis codes for MS-DRGs 485, 486, and 487 because other codes would be assigned for these conditions when they occur in the knee. We also support the addition of several diagnosis codes as principal diagnosis codes for these MS-DRGs because they describe infections of the knee.

II-F-6b – MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Neuromuscular Scoliosis (84FR19201)

AHIMA supports the addition of diagnosis codes for neuromuscular scoliosis to the list of principal diagnosis codes for MS-DRGs 456, 457, and 458 (Spinal Fusion except Cervical with Spinal Curvature or Malignancy or Infection or Extensive Fusions with MCC, with CC, and without CC/MCC, respectively).

II-F-6c – MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue): Secondary Scoliosis and Secondary Kyphosis (84FR19202)

We support the addition of diagnosis code for secondary scoliosis and secondary kyphosis to the list of principal diagnosis codes for MS-DRGs 456, 457, and 458 (Spinal Fusion except Cervical with Spinal Curvature or Malignancy or Infection or Extensive Fusions with MCC, with CC, and without CC/MCC, respectively). We also agree with the removal of diagnosis codes for conditions involving the cervical region.

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II-F-7 – MDC 11 (Diseases and Disorders of the Kidney and Urinary Tract): Extracorporeal Shock Wave Lithotripsy (ESWL) (84FR19204)

We support CMS's proposal to delete MS-DRGs 691 and 692 (Urinary Stones with ESW Lithotripsy with CC/MCC and without CC/MCC, respectively) and to re-title MS-DRGs 693 and 694 (Urinary Stones with MCC and Urinary Stones without MCC, respectively).

II-F-8 – MDC 12 (Diseases and Disorders of the Male Reproductive System): Diagnostic Imaging of Male Anatomy (84FR19210)

We support the reassignment of ICD-10-CM diagnosis codes R93.811, R93.812, R93.813, and R93.819, which describe abnormal radiologic findings on diagnostic imaging of testis, to MS-DRGs 729 and 730 (Other Male Reproductive System Diagnoses with CC/MCC and without CC/MCC, respectively).

II-F-9 – MDC 14 (Pregnancy, Childbirth and the Puerperium): Proposed Reassignment of Diagnosis Code O99.89 (84FR19211)

We agree with CMS's clinical advisors that CMS should collaborate with the National Center for Health Statistics on a proposal to expand ICD-10-CM diagnosis code O99.89, Other specified diseases and conditions complicating pregnancy, childbirth and the puerperium, to capture the specific obstetric-related stage. In the meantime, we support the reclassification of this code as an antepartum condition under MDC 14.

II-F-10 – MDC 22 (Burns): Skin Graft to Perineum for Burn (84FR19214)

We **disagree** with CMS's proposal not to add seven ICD-10-PCS codes describing skin graft to the perineum to MS-DRG 927 (Extensive Burns or Full Thickness Burns with MV >96 Hours with Skin Graft) and MS-DRGs 928 and 929 (Full Thickness Burn with Skin Graft or Inhalation Injury with CC/MCC and without CC/MCC, respectively). When principal diagnosis codes T21.37XA, Third degree burn of (female) perineum, and T21.36XA, Third degree burn of the (male) perineum, are assigned in combination with one of the ICD-10-PCS codes for skin graft to the perineum, cases group to non-surgical MS-DRG 934 (Full Thickness Burn without Skin Graft or Inhalation Injury). When surgical placement of skin grafts for burns is performed, the cases should group to surgical DRGs **with** skin grafts.

Although there were no cases in the CMS data, MS-DRGs are used by other payers, and so accurate MS-DRG grouping is important in order to ensure cases are assigned to the most appropriate MS-DRGs from both a clinical and resource utilization perspective. Therefore, **we recommend that the seven ICD-10-PCS codes describing skin graft to the perineum be added to MS-DRGs 927-929.**

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II-F-11 – MDC 23 (Factors Influencing Health Status and Other Contacts with Health Services): Proposed Assignment of Diagnosis Code R93.89 (84FR19216)

AHIMA supports the reassignment of ICD-10-CM diagnosis code R93.89, Abnormal findings on diagnostic imaging of other specified body structures, to MS-DRGs 947 and 948 (Signs and Symptoms with and without MCC, respectively).

II-F-12a(1) – Adding Procedure Codes and Diagnosis Codes Currently Grouping to MS-DRGs 981 Through 983 or MS-DRGs 987 Through 989 into MDCs: Gastrointestinal Stromal Tumors with Excision of Stomach and Small Intestine (84FR19216)

We agree that ICD-10-CM diagnosis codes for gastrointestinal stromal tumors should be moved from MDC 8 to MDC 6 and classified to MS-DRGs 326, 327, and 328 (Stomach, Esophageal, and Duodenal Procedures with MCC, with CC, and without CC/MCC, respectively).

II-F-12a(2) – Adding Procedure Codes and Diagnosis Codes Currently Grouping to MS-DRGs 981 Through 983 or MS-DRGs 987 Through 989 into MDCs: Peritoneal Dialysis Catheter Complications (84FR19217)

We agree that cases reporting a principal diagnosis of complications of peritoneal dialysis catheters with a procedure describing removal, revision, and/or insertion of peritoneal catheter or revision of synthetic substitute should group to MS-DRGs 907, 908, and 909 (Other O.R. Procedures for Injuries with MCC, with CC, and without CC/MCC, respectively) in MDC 21.

II-F-12a(3) – Adding Procedure Codes and Diagnosis Codes Currently Grouping to MS-DRGs 981 Through 983 or MS-DRGs 987 Through 989 into MDCs: Bone Excision with Pressure Ulcers (84FR19219)

We agree that cases reporting a principal diagnosis in MDC 9 with a procedure describing excision of the sacrum, pelvic bones, and coccyx should group to MS-DRGs 579, 580, and 581 (Other Skin, Subcutaneous Tissue and Breast Procedures with MCC, with CC, and without CC/MCC, respectively).

II-F-12a(4) – Adding Procedure Codes and Diagnosis Codes Currently Grouping to MS-DRGs 981 Through 983 or MS-DRGs 987 Through 989 into MDCs: Lower Extremity Muscle and Tendon Excision (84FR19220)

We agree that cases reporting ICD-10-PCS procedure codes for excision of lower extremity muscles and tendons with a principal diagnosis in MDC 10 should group to MS-DRGs 622, 623, and 624 (Skin Grafts and Wound Debridement for Endocrine, Nutritional and Metabolic Disorders with MCC, with CC, and without CC/MCC, respectively).

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II-F-12a(5) – Adding Procedure Codes and Diagnosis Codes Currently Grouping to MS-DRGs 981 Through 983 or MS-DRGs 987 Through 989 into MDCs: Kidney Transplantation Procedures (84FR19221)

AHIMA does **not** support adding ICD-10-PCS codes describing kidney transplantation to MS-DRG 264 (Other Circulatory System O.R. Procedures) in MDC 5. Kidney transplantation is not a circulatory system procedure.

We recommend that consideration be given to classifying cases with a principal diagnosis in MDC 5 and a procedure code for kidney transplantation to MS-DRG 652 (Kidney Transplant) in MDC 11, since ICD-10-CM category I13, Hypertensive heart and chronic kidney disease, captures a combination of circulatory and kidney diseases. If this reclassification is not possible, then these cases should remain in MS-DRGs 981-983.

II-F-12a(6) – Adding Procedure Codes and Diagnosis Codes Currently Grouping to MS-DRGs 981 Through 983 or MS-DRGs 987 Through 989 into MDCs: Insertion of Feeding Device (84FR19222)

We support the addition of ICD-10-PCS procedure code 0DH60UZ, Insertion of feeding device into stomach, open approach, to MDCs 1 (Diseases and Disorders of the Nervous System) and 10 (Endocrine, Nutritional and Metabolic Diseases and Disorders).

II-F-12a(7) – Adding Procedure Codes and Diagnosis Codes Currently Grouping to MS-DRGs 981 Through 983 or MS-DRGs 987 Through 989 into MDCs: Basilic Vein Reposition in Chronic Kidney Disease (84FR19223)

We agree that cases reporting an ICD-10-PCS procedure code describing reposition of basilic vein with a principal diagnosis in MDC 11 should group to MS-DRGs 673, 674, and 675 (Other Kidney and Urinary Tract Procedures with MCC, with CC, and without CC/MCC, respectively) in MDC 11.

II-F-12a(8) – Adding Procedure Codes and Diagnosis Codes Currently Grouping to MS-DRGs 981 Through 983 or MS-DRGs 987 Through 989 into MDCs: Colon Resection with Fistula (84FR19224)

We agree that cases reporting ICD-10-PCS procedure code 0DTN0ZZ, Resection of sigmoid colon, open approach, with a principal diagnosis of vesicointestinal fistula should group to MS-DRGs 673, 674, and 675 (Other Kidney and Urinary Tract Procedures with MCC, with CC, and without CC/MCC, respectively) in MDC 11.

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II-F-12c(1) – Proposed Additions for Diagnosis and Procedure Codes to MDCs: Stage 3 Pressure Ulcers of the Hip (84FR19225)

AHIMA agrees that cases reporting ICD-10-PCS procedure codes for transfer of hip muscle with a principal diagnosis in MDC 9 should group to MS-DRGs 573, 574, and 575 (Skin Graft for Skin Ulcer or Cellulitis with MCC, with CC, and without CC/MCC, respectively) in MDC 9.

II-F-12c(3) – Proposed Additions for Diagnosis and Procedure Codes to MDCs: Finger Cellulitis (84FR19226)

We agree that cases reporting an ICD-10-PCS procedure code for excision or resection of phalanx with a principal diagnosis from MDC 9 should group to MS-DRGs 579, 580, and 581 (Other Skin, Subcutaneous Tissue and Breast Procedures with MCC, with CC, and without CC/MCC, respectively) in MDC 9.

II-F-12c(6) – Proposed Additions for Diagnosis and Procedure Codes to MDCs: Gastric Band Procedure Complications or Infections (84FR19228)

We support the addition of ICD-10-PCS procedure codes for revision or removal of extraluminal device in stomach to MDC 6 in MS-DRGs 326, 327, and 328 (Stomach, Esophageal, and Duodenal Procedures with MCC, with CC, and without CC/MCC, respectively).

II-F-12c(8) – Proposed Additions for Diagnosis and Procedure Codes to MDCs: Occlusion of Left Renal Vein (84FR19229)

We do **not** support reassigning cases for varicose veins in the pelvic region when reported with an embolization procedure to MDCs 12 and 13 (Diseases and Disorders of the Male and Female Reproductive Systems). It is not clear why ICD-10-CM diagnosis code I86.2, Pelvic varices, is assigned to MDCs 12 and 13, as it represents a circulatory system disease, not a disease of the reproductive system.

We recommend that ICD-10-CM code I86.2 be reassigned to MDC 5 (Diseases and Disorders of the Circulatory System). The ICD-10-PCS procedure code describing embolization procedures for the treatment of pelvic varices is already assigned to MDC 5.

II-F-13a – Operating Room (O.R.) and Non-O.R. Issues: Background (84FR19229)

We support CMS's plan to conduct a comprehensive, systematic review of the ICD-10-PCS procedure codes. We agree that the details now available in the ICD-10-CM/PCS claims data should be leveraged to make modifications such as restructuring the current O.R. and non-O.R. designations.

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II-F-13b(1) – Operating Room (O.R.) and Non-O.R. Issues: O.R. Procedures to Non-O.R. Procedures – Bronchoalveolar Lavage (84FR19231)

AHIMA supports changing the designation of 13 ICD-10-PCS procedure codes for bronchoalveolar lavage from an O.R. procedure to a non-O.R. procedure.

II-F-13b(2) – Operating Room (O.R.) and Non-O.R. Issues: O.R. Procedures to Non-O.R. Procedures – Percutaneous Drainage of Pelvic Cavity (84FR19231)

AHIMA supports changing the designation of ICD-10-PCS procedure code 0W9J3ZX, Drainage of pelvic cavity, percutaneous approach, diagnostic, from an O.R. procedure to a non-O.R. procedure.

II-F-13b(3) – Operating Room (O.R.) and Non-O.R. Issues: O.R. Procedures to Non-O.R. Procedures – Percutaneous Removal of Drainage Device (84FR19231)

AHIMA supports changing the designation of ICD-10-PCS procedure code 0FPG30Z, Removal of drainage device from pancreas, percutaneous approach, from an O.R. procedure to a non-O.R. procedure.

II-F-13c(1) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Percutaneous Occlusion of Gastric Artery (84FR19231)

AHIMA supports changing the designation of ICD-10-PCS procedure code 04L23DZ, Occlusion of gastric artery with intraluminal device, percutaneous approach, from a non-O.R. procedure to an O.R. procedure.

II-F-13c(2) – Operating Room (O.R.) and Non-O.R. Issues: Non-O.R. Procedures to O.R. Procedures – Endoscopic Insertion of Endobronchial Valves (84FR19232)

We **disagree** with CMS's proposal to not designate endoscopic insertion of endobronchial valve as an O.R. procedure until additional analyses can be performed. Our members have indicated patients undergoing this procedure have higher average costs and longer lengths of stay than other cases in the MS-DRGs to which this procedure is currently assigned. CMS's own data supports higher severity level, higher costs, and longer lengths of stay for these patients. For these reasons, we recommend that the eight ICD-10-PCS codes describing endoscopic insertion of endobronchial valves be designated as O.R. procedures.

II-F-14c(1) – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2020: Proposed Changes to Severity Levels – Summary of Proposed Changes (84FR19235)

AHIMA recommends that the extensive changes in severity levels being proposed for 1,492 ICD-10-CM diagnosis codes be delayed until further evaluation of these changes is undertaken. Greater transparency is needed regarding the logic applied to each individual proposed change.

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Our members have indicated that the methodology CMS used is not always applied consistently across all of the proposed changes; some of the changes don't appear to meet CMS's own criteria; individual healthcare organizations' data analyses do not always agree with CMS's analysis; and the methodology and logic applied to individual proposed severity level changes is not clear. Some of the proposed changes seem illogical or inconsistent across codes, suggesting that the logic employed to make these severity level determinations may have skewed the data. For example, some conditions with a higher severity level designation appear to be clinically less severe and require fewer resources than other conditions with a lower severity level designation, and vice versa.

We support the proposed change from CC to non-CC for the Body Mass Index codes. Per the ICD-10-CM Official Coding Guidelines for Coding and Reporting, codes from category Z68, Body Mass Index [BMI] should only be assigned when there is an associated, reportable diagnosis (such as obesity).

We appreciate the proposed severity level change from non-CC to CC for ICD-10-CM code Z59.0, Homelessness, as this factor significantly impacts resource use.

We have identified specific concerns in the following categories of proposed severity level changes:

Malnutrition

ICD-10-CM code E44.0, Moderate protein-calorie malnutrition, is being proposed to change from a CC to an MCC, and code E43, Unspecified severe protein-calorie malnutrition, is being proposed to change from an MCC to a CC. It does not make sense for moderate protein-calorie malnutrition to have a higher severity level than severe protein-calorie malnutrition (ICD-10-CM code). We recommend that these proposed changes in severity level be re-evaluated.

No change has been proposed in the severity level of mild protein-calorie malnutrition (code E44.1), which is currently designated as a CC. The Academy of Nutrition and Dietetics and the American Society of Parenteral and Enteral Nutrition have indicated in a [consensus statement](#) that there is insufficient evidence to clinically distinguish mild and moderate forms of malnutrition. If that is the case, it does not seem appropriate to classify mild and moderate malnutrition to different severity levels. The severity level designation should be the same for both codes E44.0 and E44.1.

It also does not seem logical to change code E42, Marasmic kwashiorkor, from an MCC to a CC when codes E40 and E41, Kwashiorkor and Nutritional marasmus, respectively, are being retained as MCCs. Marasmic kwashiorkor is a combination of the conditions described by codes E40 and E41. We recommend that the current severity level of code E42 be retained.

Coding of malnutrition and related diagnoses may be inconsistent, possibly resulting in skewed data. The Third Quarter 2017 issue of *Coding Clinic for ICD-10-CM/PCS* advised to assign code R64, Cachexia, for a diagnosis of "emaciation" without documentation of malnutrition, but

“Emaciation” is indexed to code E41 in ICD-10-CM. This means that some cases of emaciation (without documentation of malnutrition) may have been reported as nutritional marasmus.

Heart Diseases

We disagree with the proposed change in severity level from MCC to CC for acute myocardial infarction codes. A myocardial infarction requires significant resources in terms of diagnostic tests, interventions, and monitoring. Also, ICD-10-CM codes I21.4, Non-ST elevation (NSTEMI) myocardial infarction, and I21.9, Acute myocardial infarction, unspecified, are not included in the list of diagnosis codes with proposed severity level changes. It is not clear why these two codes would retain their MCC status, but the severity level of the other acute myocardial infarction codes would be proposed to change to a CC. We recommend that all myocardial infarction codes retain their current MCC status.

We also disagree with the proposed change in severity level from MCC to non-CC for cardiac arrest codes, and the proposed change from MCC to CC for ventricular fibrillation and flutter. These conditions are acute and life-threatening, and require emergent intervention. They also require additional resources such as diagnostic testing and work-up and treatment of the underlying cause. We recommend that the diagnosis codes for cardiac arrest, ventricular fibrillation, and ventricular flutter retain their current severity level. Cardiac arrest and ventricular fibrillation are already excluded as an MCC if the patient dies.

Severe persistent asthma with (acute) exacerbation

It is inconsistent to propose changing the severity level of ICD-10-CM code J45.51, Severe persistent asthma with (acute) exacerbation, from a CC to an MCC, but not propose also changing the severity level of code J45.52, Severe persistent asthma with status asthmaticus, to an MCC. The severity level designation should be the same for both codes.

Genitourinary Conditions

AHIMA disagrees with the proposed change in severity levels for eight genitourinary ICD-10-CM codes. We recommend that the current severity levels be retained. Our members have indicated that these conditions require significant additional resources. End-stage renal disease (ICD-10-CM code N18.6) should remain an MCC, as it requires dialysis in addition to other resources. The other conditions (acute pyelonephritis, stage 4 and 5 chronic kidney disease, acute cystitis with and without hematuria, acute prostatitis, abscess of vulva) should remain CCs.

Also, while acute pyelonephritis and acute cystitis are being proposed to change from a CC to a non-CC, no change to the severity level is being proposed for urinary tract infection, site not specified (ICD-10-CM code N59.0), which is currently designated as a CC. It does not make sense for urinary tract infection of unspecified site to be designated as a CC, but not acute pyelonephritis and cystitis. As stated above, we recommend that acute pyelonephritis and acute cystitis retain their current CC status.

Obstetric Conditions

The rationale is not clear for changing the severity level from CC to non-CC for code O70.1, Second degree perineal laceration during delivery, and codes in subcategory O98.3-, Other infections with a predominantly sexual mode of transmission complicating pregnancy, childbirth and the puerperium. Given the low volume of obstetric cases in the Medicare claims data, we recommend that changes to the severity level for these codes not be made until analysis of a non-Medicare data set containing a sufficient volume of obstetric cases is performed to validate the appropriateness of these changes.

The severity level of code O98.52, Other viral diseases complicating childbirth, is being proposed to change from a CC to non-CC. However, codes O98.511, Other viral diseases complicating pregnancy, first trimester; O98.512, Other viral diseases complicating pregnancy, second trimester; O98.513, Other viral diseases complicating pregnancy, third trimester; O98.53, Other viral diseases complicating the puerperium, are also currently designated as CCs, and no change has been proposed for the severity level of these codes. For consistency, the severity level designation should be the same for all of the codes in subcategory O98.5-.

Anemia

We disagree with the proposed change in severity level from CC to non-CC for ICD-10-CM codes D61.9, Aplastic anemia, unspecified, and D62, Acute posthemorrhagic anemia, as blood transfusions may be administered, which involve additional resources as well as risks.

Code R71.0, Precipitous drop in hematocrit, is also currently a CC, and no change to its severity level is being proposed. For consistency, and to discourage miscoding, both codes D62 and R71.0 should have the same severity level.

For the reasons stated above, we recommend that codes D61.9 and D62 retain their current severity level.

Acute Postprocedural Respiratory Failure

We disagree with the proposed change in severity level from MCC to CC for ICD-10-CM code J95.821, Acute postprocedural respiratory failure. For consistency, this code should have the same designated severity level as other acute respiratory failure codes. Acute respiratory failure is a life-threatening organ failure that consumes significant resources.

Since code J95.822, Acute and chronic postprocedural respiratory failure, and codes in subcategories J96.0-, Acute respiratory failure; J96.2-, Acute and chronic respiratory failure; and J96.9-, Respiratory failure, unspecified, are designated as MCCs, we recommend that the current MCC designation be retained for code J95.821.

Diverticular Disease of Intestine

AHIMA disagrees with the proposed change in severity level from CC to non-CC for ICD-10-CM code K57.12, Diverticulitis of small intestine without perforation or abscess without bleeding. Since no severity level changes are being proposed for codes K57.32, Diverticulitis of

large intestine without perforation or abscess without bleeding, and K57.52, Diverticulitis of both small and large intestine without perforation or abscess without bleeding, we recommend that the current CC designation be retained for code K57.12. This would maintain consistency in the CC designation across all of the codes for diverticulitis of intestine without perforation, abscess, or bleeding.

We also disagree with the proposed change in severity level from MCC to CC for codes K57.31, Diverticulosis of large intestine without perforation or abscess with bleeding, and K57.33, Diverticulitis of large intestine without perforation or abscess with bleeding. We recommend that the current MCC designation be retained for code K57.12 in order to maintain consistency with other codes for diverticulosis and diverticulitis of intestine without perforation or abscess with bleeding that are designated as MCCs.

Hemorrhage of Anus and Rectum

We disagree with the proposed change in severity level from CC to non-CC for ICD-10-CM code K62.5, Hemorrhage of anus and rectum. For consistency, the severity level designation for this code should be the same as for codes K92.0, Hematemesis, K92.1, Melena, and K92.2, Gastrointestinal hemorrhage, unspecified, which are designated as CCs.

Other Foreign Object in Esophagus Causing Compression of Trachea

The severity level of code T18.190A is being proposed change from a non-CC to a CC. For consistency, we recommend that the severity level for similar codes in subcategory T18.1- be changed to a CC as well (codes T18.100A, Unspecified foreign body in esophagus causing compression of trachea, initial encounter; T18.110A, Gastric contents in esophagus causing compression of trachea, initial encounter; T18.120A, Food in esophagus causing compression of trachea, initial encounter).

Sickle-Cell Disease with Crisis

AHIMA disagrees with changing the severity level for codes for sickle-cell disease with crisis from an MCC to a non-CC. According to our members, patients with these conditions require significant additional resources.

Type 2 Diabetes Mellitus with Hyperosmolarity

We disagree with changing the severity level for code E11.00, Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma, from an MCC to a non-CC. No change in the severity level is being proposed for code E11.01, Type 2 diabetes mellitus with hyperosmolarity with coma, so this code would remain an MCC. Clinicians have told us that it is the hyperosmolar state, not the coma, that increases resource consumption. Therefore, we recommend that the MCC status be retained for code E11.00.

Acute Appendicitis with Peritonitis

We disagree with the proposed change to the severity level from MCC to non-CC for codes K35.21, Acute appendicitis with generalized peritonitis, with abscess; K35.32, Acute appendicitis with perforation and localized peritonitis, without abscess; and K35.33, Acute appendicitis with

perforation and localized peritonitis, with abscess. We also disagree with the proposed change to the severity level from CC to non-CC for codes K35.20, Acute appendicitis with generalized peritonitis, without abscess; K35.30, Acute appendicitis with localized peritonitis, without perforation or gangrene; and K35.31, Acute appendicitis with localized peritonitis and gangrene, without perforation. All of these conditions consume additional resources. We recommend the current MCC or CC status for these codes be retained.

Also, the fact that no severity level change was proposed for codes K35.80, Unspecified acute appendicitis; K35.890, Other acute appendicitis without perforation or gangrene; and K35.891, Other acute appendicitis without perforation, with gangrene, is illogical and inconsistent with the proposed changes to the other codes in category K35, Acute appendicitis. According to the proposal, codes for unspecified acute appendicitis or acute appendicitis without peritonitis or peritonitis would continue to be designated as CCs, whereas codes for acute appendicitis with peritonitis (without perforation) would be designated as non-CCs. This inconsistency in the proposed changes supports our recommendation that no changes should be made to the MCC/CC designation for the acute appendicitis codes at this time.

Postprocedural Complete Intestinal Obstruction

In addition to the proposed change in the severity level for code K91.32, Postprocedural complete intestinal obstruction, we recommend that the severity level also be changed to an MCC for other codes describing a complete intestinal obstruction (codes K56.52, Intestinal adhesions [bands] with complete obstruction; K56.601, Complete intestinal obstruction, unspecified as to cause; K56.691, Other complete intestinal obstruction). This would ensure a consistent severity level across related diagnosis codes.

Drug Resistance

While we support the proposed designation of certain drug resistance codes in category Z16 as CCs, it is not clear why only code Z16.39, Resistance to other specified antimicrobial drug, in subcategory Z16.3- would be designated as a CC, and not any other codes in this subcategory. Code Z16.39 does not identify a specific drug, as it is a code for resistance to “other specified” antimicrobial drug. Other codes in subcategory Z16.3- identify resistance to specific antimicrobial drugs or resistance to multiple antimicrobial drugs. We recommend that CMS consider designating the other codes in subcategory Z16.3- as CCs as well.

Transplant Status

We disagree with the proposed change in severity level designation from CC to non-CC for transplant status codes (category Z94). According to feedback we have received from AHIMA members, these patients require significant additional resources, including anti-rejection drugs and monitoring of organ function and/or imaging. We recommend that the current CC severity level status for transplant status codes be retained.

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II-F-14d(1) – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2020: Requested Changes to Severity Levels – Acute Right Heart Failure (84FR19246)

AHIMA recommends designating ICD-10-CM diagnosis codes I50.811, Acute right heart failure, and I50.813, Acute on chronic right heart failure, as MCCs, as the resources required are comparable to acute diastolic and/or systolic heart failure (codes I50.21, I50.31, and I50.41) and acute on chronic diastolic and/or systolic heart failure (codes I50.23, I50.33, and I50.43), which are classified as MCCs.

II-F-14d(3) – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2020: Requested Changes to Severity Levels – Ascites in Alcoholic Liver Disease and Toxic Liver Disease (84FR19247)

We recommend changing the severity level designation for codes K70.11, Alcoholic hepatitis with ascites; K70.31, Alcoholic cirrhosis with ascites; and K71.51, Toxic liver disease with chronic active hepatitis with ascites, from a non-CC to a CC, in order to be consistent with the severity level designation of other ascites codes. Both codes R18.0, Malignant ascites, and R18.8, Other ascites, are designated as CCs.

II-F-14d(7) – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2020: Requested Changes to Severity Levels – Obstetric Chapter Codes (84FR19249)

We support the proposed changes in severity level for ICD-10-CM obstetric diagnosis codes describing diabetes mellitus in order to achieve consistency in the severity level across related codes. We also support changing the severity level from non-CC to CC for code O30.023, Conjoined twin pregnancy, third trimester.

Regarding the proposed change in severity level from non-CC to CC for diagnosis codes O36.1910, Maternal care for other isoimmunization, first trimester, not applicable or unspecified, and O36.1911, Maternal care for other isoimmunization, first trimester, fetus 1, it is not clear why these codes were singled out in subcategory O36.1, Maternal care for other isoimmunization. All of the codes in subcategory O36.0, Maternal care for rhesus isoimmunization, currently have CC severity level designation. For consistency, we recommend that all codes in subcategory O36.1 (except for the codes for unspecified trimester) also be designated as CCs.

Before making any further changes in severity level designations for obstetric diagnosis codes in the future, we recommend that CMS use appropriate non-Medicare data sets for evaluation of severity level designation of obstetric diagnosis codes. We recognize that MedPAR data cannot be used to evaluate requests for changes in severity level designations for obstetric diagnosis codes due to the low volume of obstetric cases in Medicare claims data, and we do not believe this evaluation should be based solely on CMS's clinical advisors' judgment in the absence of sufficient Medicare data.

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II-F-14f – Proposed Changes to the MS-DRG Diagnosis Codes for FY 2020: Proposed CC Exclusions List for FY 2020 (84FR19250)

We support the proposed changes to the CC Exclusions List.

II-F-16a – Proposed Changes to the Medicare Code Editor (MCE): Age Conflict Edit – Maternity Diagnoses (84FR19251)

AHIMA supports expanding the age range for the maternity diagnoses category for the Age Conflict edit.

II-F-16b – Proposed Changes to the Medicare Code Editor (MCE): Sex Conflict Edit – Diagnoses for Females Only (84FR19251)

We support the addition of ICD-10-CM code N99.85, Post endometrial ablation syndrome, to the Diagnoses for Females Only edit code list under the Sex Conflict edit.

II-F-16c – Proposed Changes to the Medicare Code Editor (MCE): Unacceptable Principal Diagnosis Edit (84FR19251)

We support the addition of ICD-10-CM codes I46.2, Cardiac arrest due to underlying cardiac condition, and I46.8, Cardiac arrest due to other underlying condition, to the Unacceptable Principal Diagnosis edit code list.

II-F-16d – Proposed Changes to the Medicare Code Editor (MCE): Non-Covered Procedure Edit (84FR19252)

We agree that ICD-10-PCS procedure codes that are no longer valid should be deleted from the Non-Covered Procedure edit code list.

II-F-17 – Proposed Changes to Surgical Hierarchies (83FR19253)

We support the proposed revisions to the surgical hierarchy for MDC 5 (Diseases and Disorders of the Circulatory System).

II-H – Proposed Add-On Payments for New Services and Technologies for FY 2020 (84FR19272)

II-H-4g – Proposed FY 2020 Status of Technologies Approved for FY 2019 New Technology Add-On Payments: remedē® System (84FR19281)

According to the proposed rule, cases involving the use of the remedē® System that are eligible for new technology add-on payments are identified by ICD-10-PCS procedure codes 0JH60DZ, Insertion of multiple array stimulator generator, subcutaneous tissue and fascia, chest, open

approach, and 05H33MZ, Insertion of neurostimulator lead, right innominate vein, percutaneous approach, in combination with procedure code 05H03MZ, Insertion of neurostimulator lead into azygos vein, neurostimulator lead, percutaneous approach, or 05H43MZ, Insertion of neurostimulator lead into left innominate vein, percutaneous approach. The descriptor of code 05H03MZ is incorrectly stated in the proposed rule as involving the right innominate vein, whereas the correct body part for this code is the azygos vein.

The codes listed for the remedē® System in the proposed rule do not match the advice that was published in the Fourth Quarter 2016 issue of *Coding Clinic for ICD-10-CM/PCS* regarding insertion of a phrenic neurostimulator. *Coding Clinic* advised assigning code 0JH60MZ for the insertion of the stimulator generator into the chest subcutaneous tissue and fascia and code 05H032Z for the insertion of monitoring device into the azygos vein, plus the appropriate code for insertion of neurostimulator lead into either the left or right innominate vein. The device values for both the code for the stimulator generator and the code for the insertion of the lead in the azygos vein in the *Coding Clinic* advice were different than the ones indicated by CMS in the proposed rule. According to *Coding Clinic*, for coding purposes, the sensing lead inserted in the azygos vein is designated as a monitoring device to differentiate between the sensing lead that monitors the respiratory activity and the electrode that delivers the electrical stimulation.

Cases involving the use of the remedē® System will not be properly identified for administration of the add-on payment if hospitals are reporting different ICD-10-PCS procedure codes than the codes specified by CMS. AHIMA recommends that CMS revise its codes for placement of the remedē® System to be consistent with the advice published in *Coding Clinic for ICD-10-CM/PCS*. If CMS no longer supports the 2016 *Coding Clinic* advice, a correction should be published in a future issue of *Coding Clinic*.

VIII. QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS AND SUPPLIERS (84FR19473)

VIII-D – Proposed Changes to the Medicare and Medicaid Promoting Interoperability Programs (84FR19554)

AHIMA appreciates CMS's continued flexibility and enhanced focus on improving interoperability. We offer the following comments related to the proposed changes to the Promoting Interoperability Programs.

VIII-D-2b – Proposed EHR Reporting Period in CY 2021 (84FR19554)

AHIMA supports the 90-day reporting period for CY 2021 for new and returning participants in the Medicare Promoting Interoperability Program as proposed by CMS. We believe the shortened reporting period offers an opportunity for eligible hospitals and CAHs to implement and update measures as well as allow for adjustment to other changes being proposed as part of this rule.

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VIII-D-3 – Proposed Changes to Measures Under the Electronic Prescribing Objective
(84FR19556)

AHIMA supports CMS’s proposal to make the Query of Prescription Drug Monitoring Program (PDMP) measure optional in CY 2020 for 5 bonus points, as well as its proposal to remove the numerator and denominator established for the measure and instead require a “yes/no” attestation. We continue to be concerned that existing health information technology (IT) systems are not fully integrated with PDMPs, requiring providers to log separately into PDMP databases and manually enter the data into the certified electronic health record technology (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 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.

We are pleased that CMS recognizes these concerns and believe that such flexibility as proposed will enable early adopters of the measure to participate and potentially earn 5 bonus points, while providing additional time for CMS to restructure the measure in a manner that meets the needs of clinicians and other stakeholders. We also believe this will provide additional time for the Centers for Disease Control and Prevention (CDC) and the Office of the National Coordinator for Health IT (ONC) to advance and scale PDMP integration with health IT systems, including testing and refining of standard-based approaches to enable effective integration into clinical workflows as well as enhanced access and use of PDMP data.

AHIMA is also pleased that CMS proposes to remove the Verify Opioid Treatment Agreement measure from the Promoting Interoperability Program beginning in CY 2020. In the FY 2019 IPPS/LTCH PPS proposed rule comment period, we expressed concern that CMS did not intend to define an opioid treatment agreement as a standardized electronic document, including data elements, content structure, or clinical purpose for a document to be deemed a “treatment agreement” under the Verify Opioid Treatment Agreement measure. We are pleased that CMS intends to remove this measure, as we believe that the measure as originally conceived could lead to additional clinician burden and does not advance interoperability.

VIII-D-7e – Future Direction of the Promoting Interoperability Program: Request for Information (RFI) on the Provider to Patient Exchange Objective (84FR19566)

Should eligible hospitals and CAHs make patient health information available immediately through the open, standards-based API, no later than one business day after it is available to the eligible hospital or CAH in their CEHRT? What barriers exist to more immediate access to patient information? Are there specific data elements that may be more or less feasible to share no later than one business day?

Provided a patient’s clinical data is limited to the US Core Data for Interoperability (USCDI) standard (consistent with CMS’s Interoperability and Patient Access rule as currently proposed), we believe that it is feasible for eligible hospitals and CAHs to make patients’ electronic health

information available through an open, standards-based API no later than one business day after it is available to the eligible hospital or CAH in their CEHRT. Evidence from ONC suggests that of the eligible hospitals that use certified health IT systems, approximately 87 percent are served by health IT developers with products certified to any FHIR version.¹ Given the widespread adoption, we believe it would be appropriate for eligible hospitals to make a patient's health information available no later than one business day after it is available to the eligible hospital or CAH in their CEHRT. Additionally, we would like to underscore the importance that this timeline not begin until the information is made available to the eligible hospital or CAH in their CEHRT, as there are a number of challenges that currently delay a patient's health information from getting into the record in the first place. These challenges include lack of interfaces between EHRs and other systems where certain types of documentation reside, including imaging, backlogs in scanning of documents, and delays in authentication.

If ONC's proposal for a FHIR-based API certification criterion is finalized, would stakeholders support a possible bonus under the Promoting Interoperability Programs for early adoption of a certified FHIR-based API in the intermediate time before ONC's final rule's compliance date for implementation of a FHIR standard for certified APIs?

AHIMA supports the idea of a possible bonus under the Promoting Interoperability Programs for early adopters of a certified FHIR-based API before the compliance date of ONC's 21st Century Cures Act final rule. Such a proposal would create an incentive for stakeholders in the Promoting Interoperability Programs to adopt certified FHIR-based APIs sooner rather than later while further advancing interoperability.

Do stakeholders believe that incorporating this alternative measure (i.e., the EHI export all certification criterion) into the Provider to Patient Exchange objective will be effective in encouraging the availability of all data stored in health IT systems?

While AHIMA supports efforts to enable the export of a single patient's electronic health information upon a valid request from the patient or a user on the patient's behalf, as we noted in our [comments](#) to ONC in its 21st Century Cures Act proposed rule, we are concerned that the rule's current proposal to require EHI export to apply to a health IT system's "entire database" lacks clarity. For example, it is unclear from the preamble whether data acquired from third parties, including patient-generated health data that might be stored separately, should fall within the scope of a health IT system's entire database. Furthermore, as ONC itself acknowledges in the 21st Century Cures Act proposed rule, "It is understandable that developers will not be able to export every existing data element, nor that all possible data elements are necessary for transfer."² Given this variability, it is unclear as to how effective incorporating this alternative measure into the Provider to Patient Exchange objective would be in encouraging the availability of all data stored in health IT systems.

¹ Available at: <https://www.healthit.gov/buzz-blog/interoperability/heat-wave-the-u-s-is-poised-to-catch-fhir-in-2019>.

² Available at: <https://www.govinfo.gov/content/pkg/FR-2019-03-04/pdf/2019-02224.pdf>.

Do stakeholders believe that we should consider including a health IT activity that promotes engagement in the health information exchange across the care continuum that would encourage bi-directional exchange of health information with community partners, such as post-acute care, long term care, behavioral health, and home and community-based services to promote better care coordination for patients with chronic conditions and complex care needs? If so, what criteria should we consider when implementing a health information exchange across the care continuum health IT activity in the Promoting Interoperability Program?

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 Promoting Interoperability Program participants and increased bi-directional exchange of health information could help facilitate care coordination. Along these lines, AHIMA supports inclusion of a health IT activity that promotes engagement in health information exchange across the care continuum that would encourage bi-directional exchange of health information with community partners to promote care coordination for patients with chronic conditions and complex care needs. That said, should CMS decide to implement a health IT activity related to health information exchange across the care continuum as part of the Promoting Interoperability Program, we recommend that it take into consideration the fact that there are care settings that have not adopted certified health IT systems and may struggle with the ability to receive and exchange a patient's electronic health information compared to Promoting Interoperability Program participants.

VIII-D-7e(4) – Future Direction of the Promoting Interoperability Program: Request for Information (RFI) on the Provider to Patient Exchange Objective – Patient Matching
(84FR19568)

AHIMA supports CMS's interest in leveraging its program authority to provide support to those working to improve patient matching. Today, there is no consistent approach to accurately matching a patient to their health information, which has led to significant costs to hospitals; health systems; physician practices; long-term, post-acute care (LTPAC) facilities; and other providers. According to a 2016 study of healthcare executives, misidentification costs the average healthcare facility \$17.4 million per year in denied claims and lost revenue.³ Lack of a consistent and accurate approach to patient matching has also hindered the advancement of health information exchange across the care continuum. A 2017 study by the American Hospital Association indicates that 45 percent of large hospitals reported that difficulties in accurately identifying patients across health IT systems limits health information exchange.⁴ More importantly, there are patient safety implications when data is matched to the wrong patient and when essential data is lacking from a patient's record due to identity issues. Patient matching errors can often begin at registration and can generate a cascade of errors including wrong-site

³ 2019 National Patient Misidentification Report, Available at:

https://pages.imprivata.com/rs/imprivata/images/Ponemon-Report_121416.pdf.

⁴ AHA, Trendwatch: Sharing Health Information, Available at: <https://www.aha.org/system/files/2018-03/sharing-health-information.pdf>.

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surgery, delayed or lost diagnoses, duplicative testing, and wrong patient orders. According to the *2016 National Patient Misidentification Report*, 86 percent of respondents said they have witnessed or know of a medical error that was the result of patient misidentification.⁵

AHIMA provided a number of different recommendations in response to CMS’s Patient Matching RFI in its Medicare and Medicaid Program; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans in Federally-facilitated Exchanges and Health Care Providers (CMS-911-P) proposed rule. We refer CMS to our [response](#), in which we make several recommendations as to how CMS can leverage its program authority to advance patient matching.

AHIMA appreciates the opportunity to comment on the FY 2020 proposed modifications to the Medicare Hospital IPPS program and the proposed requirements for the Promoting Interoperability Programs. AHIMA is committed to working with CMS and the 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 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

⁵ 2019 National Patient Misidentification Report, Available at:
https://pages.imprivata.com/rs/imprivata/images/Ponemon-Report_121416.pdf.