American Health Information Management Association®

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June 8, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
US Department of Health and Human Services
Attention: CMS-1785-P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Brooks-LaSure:

On behalf of the American Health Information Management Association (AHIMA), I am responding to the Centers for Medicare & Medicaid Services' (CMS) proposed changes to the Medicare Hospital Inpatient Prospective Payment Systems (IPPS) and fiscal year (FY) 2024 rates, as published in the May 1, 2023, Federal Register (CMS-1785-P).

AHIMA is a global nonprofit association of health information (HI) professionals. AHIMA represents professionals who work with health data for more than one billion patient visits each year. AHIMA's mission of empowering people to impact health drives our members and credentialed HI professionals to ensure that health information is accurate, complete, and available to patients and providers. Our leaders work at the intersection of healthcare, technology, and business, and are found in data integrity and information privacy job functions worldwide.

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

II. PROPOSED CHANGES TO MEDICARE SEVERITY DIAGNOSIS-RELATED GROUP (MS-DRG) CLASSIFICATIONS AND RELATIVE WEIGHTS (88FR26671)

II-C – Proposed Changes to Specific MS-DRG Classifications (88FR26672)

AHIMA supports the MS-DRG classification proposals except as otherwise indicated in our comments below.

II-C-1b – Basis for Proposed FY 2024 MS-DRG Updates (88FR26672)

AHIMA is concerned about the impact of the expansion of the criteria for creating severity level subgroups within base MS-DRGs. When the NonCC criteria were applied to existing MS-DRGs currently split into three severity levels, as well as when these criteria were applied to new MS-DRG classification requests, none of the new proposed MS-DRGs with a two-way severity level split involved a "with CC/MCC" and "without CC/MCC" split. The impact of the presence of a CC on MS-DRG assignment appears to be declining because the application of the NonCC subgroup criteria is resulting in fewer MS-DRGs split by the presence of a CC.

The fluctuations in proposed MS-DRG restructuring when the NonCC criteria were applied to different sets of claims data and presented in the FY 2022, 2023, and 2024 IPPS proposed rules are concerning. While we appreciate CMS' detailed analysis of the proposed MS-DRG changes, it is challenging for the healthcare industry to fully assess the impact when the proposed changes vary considerably depending on the set of claims data used for the analysis. Given the variability in the proposed MS-DRG changes, it is quite possible that when CMS decides to move forward with implementation of the changes to existing MS-DRGs resulting from application of the expanded three-way severity split criteria, the data analysis conducted at that time may result in yet another set of proposed MS-DRG changes that differ from the lists put forth in previous fiscal years. CMS acknowledged in the FY 2023 IPPS final rule that, because there is variation in the claims data reported from year to year, it is expected that there may be fluctuations in the data that could affect the list of MS-DRGs potentially subject to change in connection with the application of the NonCC subgroup criteria for a particular fiscal year. However, the differences in the lists of proposed MS-DRG changes from year to year are quite substantial. CMS' stated purpose of adding the NonCC subgroup criteria was to better reflect resource stratification and promote stability in the relative weights. The results of CMS' own data analyses do not align with this purpose, nor do they support re-structuring MS-DRGs – not when multiple data analyses do not produce stable and reliable results.

We recommend that CMS conduct a full analysis that demonstrates the explanatory power of the proposed MS-DRGs (resulting from the expanded three-way severity split criteria) is an improvement over the current MS-DRGs. This analysis should also include an assessment of the impact on CCs, particularly on the "with CC/MCC" subgroup.

II-C-4b – Respiratory Infections and Inflammations Logic (88FR26691)

We recommend that the five influenza codes (J10.00, J10.01, J10.08, J11.00 and J11.08) listed as principal diagnoses in the first logic list for MS-DRGs 177, 178, and 179 (Respiratory Infections and Inflammations with MCC, with CC, and without CC/MCC, respectively) be allowed as MCCs with a principal diagnosis from the second logic list. Influenza is not inherently related to the principal diagnoses on the second logic list, and, in combination, they have the potential to be more complicated and resource intensive to treat than any of the diagnoses occurring alone.

We agree with excluding the 10 secondary diagnoses in the first logic list when one of these codes is reported as a secondary diagnosis with a principal diagnosis code from the second logic list.

II-C-5a – Surgical Ablation (88FR26691)

AHIMA supports the creation of a new base MS-DRG for cases reporting an aortic valve repair or replacement procedure, a mitral valve repair or replacement procedure, and another concomitant procedure in MDC 05.

We recommend that CMS review the ICD-10-PCS codes for procedures involving the mitral and aortic valve listed under "Other Concomitant Procedure" in table 6P.4a associated with the FY 2024 IPPS proposed rule and consider whether these procedure codes should be moved to the Mitral Valve or Aortic Valve Repair/Replacement list. In ICD-10-PCS, the root operation "Repair" is used only when the method to accomplish the repair is not one of the other, more specific, root operations. We believe procedures describing supplement or restriction of the mitral or aortic valve, and perhaps additional procedures such as dilation and release, represent a type of valvular repair and should be included on the Mitral Valve or Aortic Valve Repair/Replacement logic list rather than the Other Concomitant Procedure logic list.

The title of the proposed new MS-DRG (Concomitant Aortic and Mitral Valve Procedures) is not clear. The title suggests that this MS-DRG is limited to cases involving an aortic valve procedure performed in conjunction with a mitral valve procedure. The title should more clearly reflect that this MS-DRG is intended for cases reporting an aortic valve repair or replacement procedure, a mitral valve repair or replacement procedure, and another concomitant procedure in MDC 05. A possible alternative code title is "Aortic and Mitral Valve Procedures with a Concomitant Circulatory System Procedure."

II-C-5b – External Heart Assist Device (88FR26695)

We support the proposed reassignment of ICD-10-PCS code 02HA0RZ (Insertion of short-term external heart assist system into heart, open approach) from MDC 05 in MS-DRG 215 to Pre-MDC MS-DRGs 001 and 002.

CMS noted in the proposed rule that a code proposal requesting a new ICD-10-PCS procedure code to describe the Impella® 5.5 with SmartAssist® System was submitted for consideration as an agenda topic to be discussed at the March 7-8, 2023 ICD-10 Coordination and Maintenance (C&M) Committee meeting. Because the decisions on the code proposals presented at the March C&M meeting are not finalized in time to include in Table 6A associated with the IPPS proposed rule, CMS indicated they use their established process to examine the MS-DRG assignment for the predecessor codes to determine the most appropriate MS-DRG assignment. However, the C&M code proposal involved new codes for the conduit to a short-term external heart assist system, not a new code for the insertion of the external heart assist system itself. Even if the new codes are approved, the open insertion of a short-term external heart assist system would continue to be coded using existing code 02HA0RZ. If approved, one of the new codes would be assigned as an additional code to describe the use of an axillary artery or ascending thoracic aorta conduit.

II-C-5d – Coronary Intravascular Lithotripsy (88FR26706)

AHIMA supports the creation of new MS-DRGs for coronary intravascular lithotripsy. However, **we recommend that CMS consider subdividing proposed new MS-DRG 325 (Coronary Intravascular Lithotripsy without Intraluminal Device) into two severity levels (with and without MCC)**. CMS stated in the rule that while there is not a large number of cases reporting percutaneous coronary intravascular lithotripsy without the insertion of an intraluminal device in the Medicare data, and they generally prefer not to create a new MS-DRG unless it would include a substantial number of cases, they believe creating a separate MS-DRG for these cases would appropriately address the differential in resource consumption. Since there were only 404 cases of coronary intravascular lithotripsy without the insertion of an intraluminal device in the claims data, the criterion that there be at least 500 cases in each severity level subgroup could not be met. However, just as CMS decided to create an MS-DRG for coronary intravascular lithotripsy without an intraluminal device to address differences in resource consumption, we believe MS-DRG should be split into two severity levels (with and without MCC) to recognize increased resource utilization when an MCC is present.

We support the creation of proposed new MS-DRGs 321 (Percutaneous Cardiovascular Procedures with Intraluminal Device with MCC or 4+ Arteries/Intraluminal Devices) and 322 (Percutaneous Cardiovascular Procedures with Intraluminal Device without MCC).

We also support the revision of the titles for MS-DRGs 250 and 251 to better reflect the ICD-10-PCS terminology of "intraluminal devices" versus "stents" as used in the procedure code titles within the classification.

II-C-5e – Shock (88FR26712)

AHIMA agrees with CMS that it is no longer necessary to subdivide the MS-DRGs for cases reporting a cardiac defibrillator implant based on the diagnosis code reported. However, **we recommend that an additional MS-DRG be created for cardiac defibrillator implant with cardiac catheterization without MCC.** CMS' proposal includes the creation of one base MS-DRG for cases reporting a cardiac defibrillator implant with cardiac catheterization and a secondary diagnosis designated as an MCC and another base MS-DRG split by a two-way severity level subgroup for cases reporting a cardiac defibrillator implant without cardiac catheterization. It is not clear where cases reporting a cardiac defibrillator implant with a cardiac catheterization without MCC would be classified.

II-C-11 – Operating Room (O.R.) and Non-O.R. Procedures (88FR26743)

AHIMA supports CMS' plan to conduct a comprehensive, systematic review of the ICD-10-PCS procedure codes and evaluate current O.R. and non-O.R. designations. We agree that a re-structuring of these designations may be warranted as a result of the expanded detail in the ICD-10-PCS classification and changes in medical practice. We concur with CMS' decision to allow for additional time to develop the process and methodology, and we look forward to commenting on CMS' data analysis and methodology in the future.

II-C-12c – Overview of Comprehensive CC/MCC Analysis (88FR26746)

We acknowledge that CMS is continuing to conduct a comprehensive CC/MCC analysis and recommend that CMS carefully evaluate the CC severity level in particular as part of this process. We are concerned by the diminished impact of CCs as a result of the expansion of the criteria for creating severity level subgroups. As noted above, the expansion of the criteria to include the NonCC subgroup for a three-way severity split has resulted in two-way severity splits that recognize MCCs but not CCs. We urge CMS to analyze the impact the change in the criteria is having on the "with CC/MCC" tier, consider modifying the methodology to prevent the loss of this tier, and ensure the MS-DRG system continues to recognize the impact of the CC severity level on resource consumption.

II-C-12c – Proposed Changes to Severity Levels (88FR26748)

AHIMA supports designating the three ICD-10-CM diagnosis codes for homelessness as CCs. However, we are concerned that the value of designating homelessness as a CC has diminished due to the elimination of many "with and without CC/MCC" MS-DRG pairs resulting from expansion of the criteria for subdividing a base MS-DRG.

II-C-14 – Proposed Changes to the Medicare Code Editor (MCE) (88FR26752)

AHIMA supports the proposed MCE changes, with the additional comments noted below.

II-C-14c – Sex Conflict Edit (88FR26755)

We appreciate CMS 'commitment to look holistically at concerns raised by a commenter regarding the sex conflict edit across all settings of care. We support the continued application of the sex conflict edit, as it plays an important role in coding error detection and ensuring claims submission accuracy.

While we recognize that condition code 45 is intended to allow the sex conflict edit to be overridden for appropriate payment for certain procedures, our members have told us that it is challenging to accurately assign the appropriate MS-DRG during the coding process because of the sex conflict.

IX. PROPOSED QUALITY DATA REPORTING REQUIREMENTS FOR SPECIFIC PROVIDERS (88FR27074)

IX-F – Proposed Changes to the Medicare Promoting Interoperability Program (88FR27155)

Proposed EHR Reporting Period in CY 2025 for Eligible Hospitals and Critical Access Hospitals (CAHs)

AHIMA urges CMS to delay implementation of the proposed extended reporting period of any continuous 180-day period until the healthcare system has fully recovered from impacts of the

COVID-19 pandemic. While the COVID-19 public health emergency (PHE) recently concluded, the pandemic has generated persistent issues related to provider burnout and staffing shortages that continue to be disruptive to the functioning of healthcare organizations, and many are still working to return to pre-pandemic staffing levels and normal operating procedures.[1]

Eligible hospitals, CAHs, and other health care organizations need more time to recover from the burdens COVID-19 placed on them, particularly as the PHE unwinding process continues. The conclusion of the PHE ended several wide-ranging flexibilities and waivers related to telehealth, payment and quality reporting, continuous health coverage requirements, provider relief funding, and scope of the healthcare workforce.[2] Healthcare organizations and providers need more time to return to the traditional reporting and regulatory landscape as they adjust clinical and administrative processes until all flexibilities expire, some of which end as late as December 2024.

Proposed Changes to the EHR Reporting Period for a Payment Adjustment Year for Eligible Hospitals

AHIMA reiterates the recommendation of delayed implementation of the proposed 180-day reporting period. However, when the extended reporting period is implemented, AHIMA supports the proposal to remove the October 1 deadline. We appreciate CMS simplifying the regulatory language and we encourage CMS to continue these efforts in other areas of regulatory policy throughout the Promoting Interoperability program.

Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)

The SAFER Guides are valuable in guiding health care organizations through assessments of the welfare of their EHR systems and highlighting areas that can be addressed to improve secure health information exchange. AHIMA supports the requirement for health care organizations to complete the SAFER Guides assessment and broadly supports CMS' proposal to require an assessment of all SAFER Guides with an attestation of "yes". However, if finalized, AHIMA strongly urges CMS to first update all nine SAFER Guides with current evidence and recommendations before requiring the assessment with an attestation of "yes." This is particularly essential since an attestation of "no" under this proposal would subject the eligible hospital or CAH to a downward payment adjustment.

The SAFER Guides were initially created in 2016 and have not been updated since, while the electronic development of the healthcare industry has changed substantially with more improvements in data exchange, as well as increased challenges. The industry has made advancements in technology to support interoperability and efficiency,[3] but healthcare organizations have also experienced a change in the type and severity of cyber threats and data

[1] https://www.usnews.com/news/health-news/articles/2022-07-28/staff-shortages-choking-u-s-health-care-system
[2] https://www.cms.gov/files/document/what-do-i-need-know-cms-waivers-flexibilities-and-transition-forward-covid-19-public-health.pdf
[3] https://www.healthit.gov/topic/interoperability

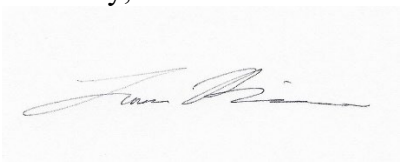
breaches.[4] AHIMA strongly encourages CMS to collaborate with the Office of the National Coordinator for Health Information Technology (ONC) to update the SAFER Guides prior to requiring eligible hospitals and CAHs to report on all nine SAFER guides. ONC and CMS should use current evidence and recommendations to update the guides to ensure healthcare organizations have access to reliable and timely resources. An update to the guides will ensure the safety of hospital and CAH EHR systems and will assist in compliance activities that do not overly burden providers.

Proposed Changes to Calculation Considerations Related to Counting Unique Patients or Actions

AHIMA supports CMS' proposal to add the response option of "N/A (measure is Yes/No)" for eligible hospitals and CAHs reporting on measures for the Medicare Promoting Interoperability Program for which there is no numerator and denominator, and for which unique patients or actions are not counted. Currently, there exists the potential for participants to record 0/0, which is an unsuitable response for those measures that do not have a numerator and denominator. AHIMA applauds CMS for modifying the regulation to allow participants to provide the appropriate response option and appropriately attest to these various measures.

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, or Tara O'Donnell, regulatory health policy associate, at (312) 233-1150 or tara.odonnell@ahima.org.

Sincerely,



Lauren Riplinger, JD
Chief Public Policy and Impact Officer

[4] https://ocrportal.hhs.gov/ocr/breach/breach_report.jsf