American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

August 26, 2020

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, D.C. 20201

Dear Administrator Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, **the American Hospital Association (AHA) urges the Centers for Medicare & Medicaid Services (CMS) to provide additional flexibility regarding the agency's new COVID-19 test documentation requirement for the diagnostic-related group (DRG) add-on payment. This new requirement will put substantial administrative burden on hospitals at a time when they are focusing their efforts and resources on critical patient care. Thus, we urge CMS to allow provider documentation to suffice if the test result is unavailable.**

The Coronavirus Aid, Relief, and Economic Security Act provided for the duration of the public health emergency a 20% add-on to the inpatient prospective payment system (PPS) DRG rate for patients diagnosed with COVID-19. As hospitals continue to be on the front lines of this pandemic, this policy was intended to support their patient care efforts in recognition of the high costs of treating COVID-19 patients. CMS has been implementing the policy based on the presence of certain International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes on the claim, which identify that a patient is diagnosed with COVID-19. The codes are:

- B97.29 (Other coronavirus as the cause of diseases classified elsewhere) for discharges occurring on or after January 27, 2020, and on or before March 31, 2020.
- U07.1 (COVID-19) for discharges occurring on or after April 1, 2020, through the duration of the COVID-19 public health emergency period.

On Aug. 17, CMS updated its guidance related to the DRG add-on payment, adding the requirement to have a positive COVID-19 laboratory test documented in the patient's medical record in order for the claim to be eligible. The new requirement would apply to

inpatient admissions occurring on or after Sept. 1, 2020, just two weeks after the guidance was released. Specifically, the guidance explains that positive tests must be demonstrated using only the results of viral testing (i.e., molecular or antigen), and that the test generally must be performed during or up to 14 days prior to the hospital admission. A test performed by an entity other than the hospital (e.g., a local government-run testing center) would satisfy the requirement if the result is manually entered into the patient's record.

The AHA is concerned about the undue burden that this new requirement will put on hospitals, and we urge the agency to continue flexibility in eligibility for the DRG add-on payment – as has been the policy since the beginning of the COVID-19 emergency.

Importantly, coding rules have allowed application of available codes on the basis of provider documentation that the patient had COVID-19. Per official ICD-10-CM coding guidance, only *confirmed* diagnoses may be coded with U07.1 (COVID-19) on the claim. Recently released guidance specifically states that "In this context, 'confirmation' does not require documentation of a positive test result for COVID-19; the provider's documentation that the individual has COVID-19 is sufficient. **Basing the COVID-19 diagnosis code on clinical judgment alone – in line with coding rules – continues to be an important approach given that test accuracy may not be reliable, re-testing is unnecessarily onerous, and some communities face persistent testing shortages, as described below.**

Moreover, current coding guidance further instructs that code U07.1 may *not* be assigned when the provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19. As a result, the usage of the code U07.1, which identifies COVID-19 claims, would be limited only to confirmed cases. **The U07.1 diagnosis code therefore remains sufficient for identifying COVID-19 cases for the DRG add-on policy.**

We are concerned that requiring a positive test will lead to unnecessary additional testing and administrative burden. We have heard from our hospital members that acquiring test results from other health care providers, local testing centers and other third party entities can be a burdensome process, sometimes resulting in long delays or unobtainable results. In order to receive the add-on payment, hospitals would have to dedicate considerable time and effort to obtain a patient's third party result to manually add into the medical record, and in some cases would ultimately have to re-test the patient. And, because some labs continue to experience protracted turnaround times, ordering a re-test may still not guarantee timely results for the hospital to include in the medical record.

In addition, some COVID-19 patients may be hospitalized for a reoccurrence or other concurrent conditions, which still require hospitals to devote additional resources for

care for infection control and potential complications. In these cases, a COVID-19 test may have been performed outside of the 14-day window, necessitating that hospitals re-test the patient to obtain the add-on payment – despite already having clinical information to substantiate diagnosis. The new guidance states that, in certain cases where the test result was performed more than 14 days prior to hospitalization, the agency will consider whether there are complex medical factors in addition to the test result for purposes of the documentation requirement. However, because it is not clear which medical factors CMS would consider to be complex or how the agency would make its determination, providers may likely re-test the patient to ensure the add-on payment criteria are met.

Moreover, the reliability of currently available COVID-19 tests is variable, with some experts highlighting a concerning frequency of false negative tests. Less sensitive tests could demonstrate negative results despite an appropriate and accurate clinical diagnosis of COVID-19. This could similarly lead to unnecessary re-testing until a test shows a positive result.

Because use of the COVID-19 ICD-10-CM code already requires clinical documentation of diagnosis as described above, re-testing in these cases would have the sole purpose of including a positive result in the medical record. This is not only unduly burdensome and potentially wasteful, but it also may lead to longer hospital stays, higher costs and additional discomfort for patients who are already suffering.

Lastly, shortages of testing supplies continue to saddle health care providers in many parts of the country. A requirement to include a positive test result could have disproportionate impacts on lower-resourced providers, including small and rural PPS hospitals, who may not have capacity and resources to test and re-test when a patient is already diagnosed with COVID-19 by a clinician.

In light of these issues, we urge CMS to allow provider documentation of COVID-19 diagnosis to be sufficient for the DRG add-on if the test result is unavailable.

We appreciate your ongoing efforts in support of our nation's hospitals and health systems during this unprecedented public health emergency. Please contact me if you have questions or feel free to have a member of your team contact Erika Rogan, AHA senior associate director for policy, at (202) 626-2963 or erogan@aha.org.

Sincerely,

/s/

Ashley Thompson
Senior Vice President, Public Policy Analysis and Development