American Health Information Management Association
201 West Lake Street, 226
Chicago, IL 60606

September 8, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Oz:

On behalf of the American Health Information Management Association (AHIMA), I am writing in response to the Centers for Medicare and Medicaid Services (CMS) calendar year (CY) 2027 Medicare Physician Fee Schedule (PFS) Proposed Rule published in the July 16, 2026 *Federal Register* (CMS-1848-P).

AHIMA is a global nonprofit association of health information (HI) professionals, with over 61,000 members and more than 88,500 credentials in the field. The AHIMA 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 clinicians. Leaders within AHIMA work at the intersection of healthcare, technology, and business, occupying data integrity and information privacy job functions worldwide.

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

II. Provisions of the Rule for the PFS

D. Valuation of Specific Codes Including Potentially Misvalued Services Under the PFS

(27) Maternity Care Services

CMS is seeking comment on whether CMS should create HCPCS G-codes that would maintain the current coding and payment for maternity services.

AHIMA opposes the creation of HCPCS G-codes in lieu of adopting the new CPT codes for maternity care services. As CMS acknowledged in the proposed rule, the CPT code changes reflect clinical consensus regarding the reporting of contemporary maternity care.

CMS expressed concern that adopting the new CPT codes could be disruptive because longstanding clinical practice and billing patterns have developed around the existing code structure. However, maintaining an outdated structure also carries significant consequences. As explained in the rationale presented to the American Medical Association's CPT Editorial Panel, the existing global maternity codes no longer accurately describe the care provided during the antepartum, labor management, and postpartum periods.

Obstetric practice has evolved substantially, and the CPT code set must be updated to accurately capture current patterns of care, including services provided during antepartum visits, transfers from rural health facilities to tertiary care centers, and increased postpartum monitoring. The current lack of sufficiently granular data on antepartum, labor management, and postpartum care limits large-scale analyses of the relationship between care delivery and pregnancy outcomes. It also impedes efforts to understand and reduce maternal morbidity and mortality.

In addition to the compelling clinical and data-related rationale for adopting the new CPT codes, creating HCPCS G-codes that duplicate CPT codes for the same services would undermine coding standardization. Such an approach would require providers to report the same service differently depending on the payer, creating unnecessary administrative burden and increasing the potential for coding errors. It would also fragment the resulting data and reduce its comparability across payers and care settings. AHIMA therefore urges CMS to adopt the new CPT codes rather than establish duplicative HCPCS G-codes.

H. Current Procedural Terminology (CPT) Request for Information

CMS seeks public comment on several areas regarding the influence of the CPT® coding system and process on physician payment policy.

AHIMA has long advocated for a robust, single procedural coding system for reporting healthcare services, procedures, laboratory tests, and other clinician services. In 1997, the National Committee on Vital and Health Statistics also recommended the adoption of a single procedural classification system. We appreciate CMS' exploration of this area to identify opportunities to streamline coding and payment processes in healthcare. AHIMA is one of the Cooperating Parties responsible for developing and approving the *ICD-10-CM/PCS Official Guidelines for Coding and Reporting* and official coding advice. AHIMA also provides coding expertise to the CPT Editorial Panel in a non-voting advisory capacity.

While each coding system serves a role in enabling precise and accurate documentation, the use of multiple coding systems adds administrative complexity and increases the costs of using and maintaining those systems across providers, payers, and technology platforms. These burdens affect coding, billing, claims adjudication, analytics, clinical decision support, compliance auditing, utilization review, and care management. Using multiple code sets also results in separate databases that require complex cross-mapping and the translation of quality measures to support population health analyses and cost and quality comparisons, thereby hindering transparency and interoperability.[1] In addition, staff must be trained in each coding system and continually maintain their knowledge of the applicable coding rules and guidelines.

A single procedural coding system could reduce these costs and burdens by promoting standardization and improving the uniformity and usability of healthcare data across the healthcare industry.[2] Potential benefits of adopting a single procedural coding system include:

- Consistent representation of the same procedure across healthcare settings;
- Improved longitudinal tracking as patients move across settings;
- Reduced duplicate coding and less need for data crosswalks and reconciliation;

[1]Available at: https://www.healthaffairs.org/content/forefront/s-time-standardize-single-code-set-reporting-health-care-services.
[2]Available at: https://www.gao.gov/assets/gao-02-796.pdf.

- Fewer semantic discrepancies and less information loss;
- More comparable quality, utilization, public health, and research data;
- Easier exchange of procedure information among EHRs, payers, registries, and public agencies;
- Simplified education, software maintenance, validation, and governance; and
- Reduced administrative costs and fewer opportunities for coding inconsistency.

A single procedural coding system accompanied by one authoritative source of coding guidelines could also reduce the time and costs healthcare organizations incur when researching reporting requirements, addressing denials and rejections of correctly coded claims, and working with payers to resolve coding issues.[3]

At the same time, transitioning to a single procedural coding system would require substantial effort, time, and financial resources. A successful transition would depend on the full commitment and support of federal and private payers, healthcare providers, and vendors to ensure consistent implementation and application of any new coding rules and guidelines.[4]

In the RFI, CMS identifies ICD-10-PCS as a possible replacement for the CPT coding system. Although ICD-10-PCS may warrant consideration because of its widespread use and familiarity within the healthcare system, it has not been adequately tested for use outside the hospital inpatient setting. Moreover, because ICD-10-PCS was originally developed for reporting inpatient procedures, it would need to be expanded to represent services provided exclusively in outpatient settings, including physician office visits, which are currently reported using CPT evaluation and management codes.

If CMS is interested in pursuing ICD-10-PCS, or another existing code set, as a single procedural coding system, it is critical that the agency conduct a rigorous study and evaluation. The evaluation should examine the suitability and effectiveness of the coding system across all healthcare settings, payer types, and categories of healthcare services. CMS should also assess the implementation and long-term costs and benefits of transitioning to and maintaining a single coding system compared with continuing to operate multiple systems. Finally, CMS should develop and seek public comment on a proposed implementation strategy that addresses the selected code set's interactions with other coding systems, including ICD-10-CM and HCPCS Level II.

CMS also asks in the RFI whether private competition could be permitted to supplement the existing CPT-4 coding standard. AHIMA questions how privately developed, competing code sets could operate within the U.S. healthcare system without undermining the standardization and interoperability essential to consistent coding, data exchange, and healthcare administration. Absent a unified national standard and governance framework, such an approach could increase administrative complexity, create inconsistencies across payers and care settings, and further fragment healthcare data.

Regardless of the path CMS chooses, any change to the use of CPT – or the adoption of another procedural coding system – would significantly affect the healthcare industry, requiring software and system changes across payers, providers, and other industry partners, as well as extensive staff and coder retraining. If CMS considers changing how CPT is used or adopting an alternative single procedural coding system, AHIMA urges CMS to use formal notice-and-comment rulemaking to ensure that industry stakeholders with relevant expertise are meaningfully

[3]Available at: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/Downloads/051701SummaryReport.pdf.
[4]Available at: https://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/Downloads/051701SummaryReport.pdf.

involved in evaluating, planning for, and preparing for any changes. AHIMA and its national network of HI professionals are uniquely positioned to assist CMS in researching and evaluating potential coding systems, developing an appropriate implementation strategy, and designing a new maintenance model and process.

III. Other Provisions of the Proposed Rule

I. Proposed Changes to the Quality Payment Program MIPS Promoting Interoperability Performance Category

X. Request for Information on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability

CMS seeks input on potential actions to address interoperability and duplicate testing concerns related to the sharing of diagnostic imaging data and laboratory testing results.

AHIMA appreciates CMS' attentiveness to the issues associated with siloed diagnostic imaging data and laboratory testing results and the impact that this fragmented data sharing environment can have on patient care. AHIMA has long been committed to improving the exchange of health data to better enable clinicians' ability to provide informed and tailored care for their patients.

While the concerns posited by CMS are valid, the explored mechanisms listed in the RFI to address those concerns are misdirected. The fundamental issue underlying the lack of imaging data and testing results exchange is the healthcare ecosystem's longstanding challenge with achieving interoperability. Healthcare organizations, payers, and other key partners are not equipped to exchange this information with the current mechanisms for data exchange. Added layers to this issue include that imaging is often contained in distinct, separate modules that are not part of the traditional electronic health record (EHR), differences in software across entities serve as barriers to exchange, and processes and standards for achieving interoperability are different across entities. HI professionals note that even data exchange between like EHRs for imaging data is not robust or seamless in many cases.

Aside from interoperability challenges, the variations in the needs of unique patients, testing capabilities, and assessments from different testing and imaging machines and products all differ across providers. Laboratory testing done at different facilities on different machines provide different results. Each machine and testing facility has different thresholds and ranges for normal and abnormal results. For example, one HI professional noted that one point higher on a hemoglobin test can cause the patient to need a transfusion in some facilities. This causes an inability to independently evaluate one test or compare different tests done at different facilities, which is another underlying factor CMS should consider when evaluating the volume of diagnostic imaging and laboratory testing. Patients are unique, their conditions are unique, and their testing results can change significantly across visits. Primary care entities often provide basic labs while specialists need to obtain more detailed and specific labs that often need to be repeated. Second opinions, which may include further testing and evaluation, are also a factor to be considered in the pursuit of providing the best care possible for patients.

Another challenge in this space is the differences across benefits covered by payers. HI professionals attest that payer policies change constantly, and providers are often not aware of or notified when policies change. Tests and imaging can be limited and/or the amount paid for those services can change at any time. Given all these factors, placing limits on when imaging and tests can be repeated and how much entities would be paid for those tests would be a barrier to care. Any of the testing or payment restrictions discussed in the RFI would undoubtedly trickle down to patients in the form of higher out-of-pocket costs. Patients already struggle with access to healthcare and many avoid services or care when they are worried about cost.

AHIMA believes penalizing providers and patients for a perceived high volume of diagnostic imaging and laboratory tests is not the answer. First, we encourage CMS to continue to provide incentives to healthcare organizations, particularly lower resourced, smaller, and rural providers, to invest in healthcare information technology. Even with widespread EHR adoption, incentives and support continue to be a fundamental need to support ongoing costs and upgrades, training for staff, and new technology developments that aim to improve the healthcare experience for patients and providers. Those incentives are even more important for the many ophthalmologists, physical therapists, dentists, and others who often don't use commonly available EHRs, but would in many cases need more expensive technologies to participate in the type of exchange CMS has discussed in this RFI.

AHIMA also encourages CMS to consider partnering with federal agencies such as the Centers for Disease Control and Prevention (CDC), evaluate current opportunities within the LOINC coding system, and revisit Clinical Laboratory Improvement Amendments (CLIA) regulations. Avenues such as these may provide opportunities to implement standards for high, low, and critical value markers across the healthcare system. With robust participation and feedback from end-users who are involved in these processes, including HI professionals, standardizing the reporting ranges may help address the issue of different facilities having different baseline numbers. Additionally, AHIMA recommends CMS engage work with the Data Usability Taking Root Movement,[5] to understand how the private sector led initiative is advancing the creation of usable laboratory data to support patient care. By engaging in the Taking Root Movement, CMS can hear directly from those generating and exchanging lab data on how regulations can support broad data usability. However, AHIMA feels CMS should not have minimum standards for result shareability. Rather, at this time, CMS should prioritize investigating why providers cannot share this information rather than imposing standards for result shareability that would be premature. Many of the culprits are likely due to challenges in sharing data more broadly, gaps in technology capabilities, and more of the factors discussed above. With the right information, CMS can address the root causes of these barriers in data exchange and overcome them more efficiently.

AHIMA and HI professionals are committed to serving as a partner to CMS in addressing these gaps in data exchange of diagnostic imaging and laboratory testing results by working together to improve fundamental challenges in interoperability, standards, and resources.

IV. Updates to the Quality Payment Program

(4) MIPS Promoting Interoperability Performance Category

(b) Proposal To Modify the Definition of Certified Electronic Health Record Technology in the MIPS Promoting Interoperability Performance Category

CMS proposes to amend the definition of certified electronic health record technology (CEHRT) by removing references to certification criteria that has been proposed for removal in the Office of the National Coordinator for Health Information Technology (ONC) HTI-5 proposed rule.

AHIMA supports CMS' intention to promote regulatory alignment by removing references to certification criteria that would be removed from the ONC Health IT Certification Program via the HTI-5 proposed rule. We support consistency in definitions of terms like CEHRT across all the US Department of Health and Human Services (HHS) programs eligible clinicians participate in and comply with, as well as alignment between the PFS and the Hospital

[5]Available at: https://sequoiaproject.org/data-usability-taking-root-community-of-practice-taking-steps-toward-actionable-health-data/.

Inpatient Prospective Payment System (IPPS). However, as indicated in our recent comments to CMS on the fiscal year (FY) 2027 IPPS proposed rule, we continue to feel this proposal is premature and we urge CMS to wait for ONC to finalize the HTI-5 policies prior to taking any concordant action in the Promoting Interoperability Program to support consistency and predictability in compliance across HHS programs.[6] If the ONC HTI-5 final rule does not include the removal of those criteria, or finalizes a revised version of the proposal, these proposed policies within the Promoting Interoperability Program of the IPPS and the Promoting Interoperability performance category in the PFS will be misaligned and cause confusion in efforts for compliance. With any proposals intended to promote alignment across programs, AHIMA urges CMS to prioritize ensuring the timelines for policies in published regulations are uniform and concordant.

In the rule, CMS states it believes the longstanding presence of some of these criteria, including the "family health history" and "patient health information capture" criteria, are fully embedded into certified health IT and widely available and used, thus warranting their removal from the Certification Program with the understanding developers will continue to offer those functionalities in their products. As we indicated in our comments to ONC on the HTI-5 proposed rule[7] and in the FY 2027 IPPS proposed rule, there is no guarantee these functionalities will continue to be offered as part of the health IT product. If finalized, these proposed removals create the ability for health IT developers to charge provider organizations for the inclusion of these functionalities, shifting cost burden onto the provider community. We urge CMS to refrain from finalizing the removal of these criteria from the definition of CEHRT at this time.

(c) Proposal To Remove ONC Direct Review and ONC-Authorized Certification Bodies (ACB) Surveillance Attestations

CMS proposes to remove the required ONC Direct Review Attestation and the optional ONC-Authorized Certification Bodies (ONC-ACB) Surveillance Attestation beginning with CY 2026 performance period/ 2028 MIPS payment year.

AHIMA supports the proposed removal of these two measures to reduce unnecessary reporting and administrative burden, as long as these processes continue to exist and are required under the purview of ONC. We also support finalizing the removal of these two measures to align with recently finalized policies in the CMS fiscal year (FY) 2027 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment (LTCH PPS) Final Rule.[8] The ONC Direct Review and ONC-ACB Surveillance processes are robust, comprehensive, and necessary safeguards to monitor developers' adherence to requirements, mitigate issues with health IT products, and provide assurances to healthcare providers that CEHRT functions as intended. We encourage CMS to continue to support ONC in upholding and strengthening these direct review and surveillance activities to ensure the integrity and performance of certified health IT for entities participating in the Promoting Interoperability Program.

(d) Proposal To Remove Security Risk Analysis Measure

CMS proposes to remove the Security Risk Analysis measure beginning with the CY 2027 performance period/ 2029 MIPS payment year.

---

[6]Available at: https://www.ahima.org/media/nhdd2zeo/cms-fy-2027-ipps-ahima-comments-final.pdf.
[7]Available at: https://www.ahima.org/media/04aegclb/astp-onc-hti-5-ahima-comments-final-2.pdf.
[8]Available at: https://www.federalregister.gov/documents/2026/08/04/2026-15833/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-ipps-and.

AHIMA appreciates CMS' intention with the proposed removal of the Security Risk Analysis measure to avoid duplicative regulatory requirements and the administrative burden associated with reporting on this measure which may not necessarily lead to increased best practices in security. However, we caution CMS on the burden and confusion associated with repeatedly modifying measures and proposing to remove them. In the most recent CY 2026 PFS proposed and final rule, CMS modified the Security Risk Analysis measure to require eligible entities to attest "yes" to having implemented security risk management measures sufficient to reduce risks and vulnerabilities in alignment with the HIPAA Security Rule, in addition to the current required "yes" attestation to conduct a security risk analysis. With the compliance date for that policy being January 1, 2026, entities have already begun implementing security risk management measures to comply with the updated measure, which requires significant cost, staff, and administrative resources. AHIMA urges CMS to avoid year-by-year changes like these to reduce administrative burden for entities participating in the Promoting Interoperability performance category.

If finalized, AHIMA encourages CMS to coordinate with the HHS Office for Civil Rights (OCR) to implement consistent requirements and provide funding, resources, guidance, and education for entities – particularly eligible clinicians in small, rural, and otherwise under-resourced entities – on how to best prioritize and implement security risk management practices under the purview of the HIPAA Security Rule. With the anticipated publication of the HIPAA Security Rule Final Rule in the next year, we urge CMS to work with OCR and consider the feasibility of entities to implement new security policies and workflows that may result from that rulemaking. Understanding entities' financial and staff bandwidth, resource levels, and technical capabilities and adjusting compliance accordingly will more likely ensure meaningful strides in security rather than a punitive approach. This may include tiered implementation and compliance, as well as providing incentives, support, and technical assistance.

(e) Proposal To Adopt a New Electronic Prior Authorization for Prescription Drugs Measure Beginning With the CY 2028 Performance Period/ 2030 MIPS Payment Year

CMS proposes to adopt a new Electronic Prior Authorization for Prescription Drugs measure in the Health Information Exchange objective. The measure requires a yes/no response for requesting a prior authorization electronically using CEHRT for at least one prescription drug ordered by the MIPS eligible clinician during the performance period for which prior authorization is required.

AHIMA supports the proposed addition of a new Electronic Prior Authorization for Prescription Drugs measure to align with the goals of moving towards more efficient electronic prior authorization for both non-drug items and services and drugs. Drugs have long been a point of major frustration in prior authorization processes and AHIMA shares CMS' goals of leveraging the exchange of health information to streamline prior authorization.

However, MIPS eligible clinicians will depend on their payers and payer API functionality to be able to attest to this measure. The foundation and technology may be there to implement the functionality, but in many cases it is not fully functional to support end-to-end electronic prior authorization, and we encourage CMS to consider the codependent nature between clinicians and their payers' technologies in context of clinicians fulfilling this measure. AHIMA supports the measure currently proposed as an attestation rather than a frequency of use measure. However, AHIMA encourages CMS to modify this proposal to ensure a "No" response will not cause the clinician to receive a score of zero for this MIPS performance category, as technology is not currently implemented to ensure widespread adoption and use. Ensuring eligible clinicians report on the measure without fear of earning a zero score will enable CMS to gather information on the progress of the industry and whether eligible clinicians

are able to request an electronic prior authorization for drugs or not and align regulatory requirements appropriately.

(f) Proposal To Modify the Electronic Prior Authorization Measure

CMS proposes to modify the Electronic Prior Authorization measure to be an optional measure, eligible for 10 bonus points for MIPS eligible clinicians who submit a "Yes" response for the measure indicating that they have electronically requested a prior authorization through a Prior Authorization application programming interface (API) using CEHRT for at least one medical item or service (excluding drugs) ordered within the CY 2027 performance period/ 2029 MIPS payment year. CMS then proposes to make the measure required beginning with the CY 2028 performance period/ 2030 MIPS payment year.

AHIMA appreciates CMS' attentiveness to the healthcare industry's progress on implementing policies finalized under the 2024 CMS Patient Access and Interoperability Final Rule. As is well known, the healthcare industry's implementation of the required APIs and implementation guides (IGs) to enable prior authorization workflows for providers is taking more time than anticipated. We agree with CMS that, while work on implementation is underway, the community needs more time to implement and test the prior authorization APIs, demonstrate successful use of these APIs, modify workflows, update policies, and train staff. According to the most recent Workgroup for Electronic Data Interchange (WEDI) industry survey, one-third of providers have yet to start implementation and only 13 percent of payers report being at or near completion of implementation.[9] We appreciate the flexibility proposed in making the measure optional in CY 2027, however we urge CMS to refrain from proposing or finalizing any policies to make the measure required. We believe CMS should continue to follow the progress of the industry's implementation of the APIs and IGs as payers and developers of certified health IT may need more time beyond CY 2028 to test, implement, and provide these functionalities. Eligible clinicians depend on their EHR vendors and the health plans they work with to be able to successfully report on this measure, so efforts at this time are best spent working on propping up the capabilities on the developer and plan side rather than moving towards required attestations on the provider side. A shorter timeline of required reporting in CY 2028 will not spur quicker or more successful implementation.

The FHIR standard is still not mature enough to test robustly and there has not been enough testing to verify if these FHIR standards, APIs, and IGs for prior authorization would work in all real-world settings of diverse resources and characteristics. While AHIMA supports moving the industry towards use of the FHIR standard, it is still an actively maturing standard, and we encourage CMS to refrain from any measures that require the successful use of FHIR until FHIR is fully developed, tested, and implemented. We appreciate the flexibility in the proposal to make the measure optional, and we believe it should remain optional for the time being. AHIMA supports making the measure optional to provide CMS and ONC insight into industry adoption of electronic prior authorization as providers voluntarily report on this measure, and we urge CMS to focus efforts on payer and developer capabilities in the meantime. We encourage CMS to coordinate with ONC and work with the health IT vendor and payer communities to ensure that any new technical standards and/or capabilities that providers are required to report on are operational, scalable, and usable prior to provider implementation and required reporting in the Quality Payment Program.

Thank you for the opportunity to comment on the proposed rule. AHIMA continues to stand as a partner to CMS in improving meaningful policies to improve data exchange and patient health outcomes within the Medicare

[9]Available at: https://www.wedi.org/2026/03/11/wedi-survey-shows-progress-in-implementing-cms-interoperability-andprior-authorization-final-rule/.

Physician Fee Schedule and the MIPS Promoting Interoperability performance category. If you have any questions or would like to discuss our recommendations further, please contact Sue Bowman, senior director of coding policy and compliance, at Sue.Bowman@ahima.org, or Tara O'Donnell, manager of regulatory affairs, at Tara.Odonnell@ahima.org.

Sincerely,

Lauren Riplinger, JD
Chief Public Policy and Impact Officer