



## **AHIMA's Recommendations on Code Set Freeze**

### **Issue: Should ICD-9-CM and/or ICD-10-CM/PCS be frozen prior to implementation of ICD-10-CM/PCS?**

#### **Challenges**

The compliance date of October 1, 2013 for the implementation of the new code sets (ICD-10-CM/PCS) is rapidly approaching and the healthcare industry and all its stakeholders are taking steps in their planning and preparation efforts. With this change come challenges for the industry, such as implementing the Accredited Standards Committee X12 standard Version 5010, communications, training and awareness, software and systems development, and working with third parties to name a few. Trying to coordinate this changeover to the new code sets presents a very large and complex challenge to the healthcare industry. In order to conduct this substantial modification that impacts all areas of an organization, it is essential to freeze (cease updates) both the current (ICD-9-CM) and new (ICD-10-CM/PCS) code sets to enable users of the classification system enough time and opportunity to prepare for and make the transition to ICD-10-CM/PCS. While the healthcare industry is currently used to handling annual code set modifications, preparation for a transition to an entirely new code set is a much larger and more complex endeavor; incorporating additional code set modifications during the final stages of ICD-10-CM/PCS implementation preparation only adds further cost and complexity. Also, lack of constraints on the annual code set update process would mean additional modifications could range anywhere from a few new codes to many new codes, or a significant change, such as the addition of a new character value, that impacts hundreds of codes.

Detailed below is an overview of the importance of ceasing (freezing) code set updates to allow both the federal government and the healthcare industry to focus their limited resources on the ICD-10-CM/PCS conversion process without the additional cost and complexity of addressing ongoing code set updates at the same time.

#### **AHIMA's Recommendations**

- There should be no Fiscal Year (FY) 2013 ICD-9-CM code update. This would mean the last ICD-9-CM update would be FY 2012 (October 2011).<sup>i</sup>
- No updates should be made to ICD-10-CM/PCS for FY 2013 or FY 2014. The last update to ICD-10-CM/PCS after FY 2012 would be FY 2015; the FY 2012 update to ICD-10-CM/PCS should include any changes necessitated by the FY 2012 ICD-9-CM code update.

- Exceptions should be allowed for urgently needed codes during the years when there are no code updates (that is, those that can make a “clear and convincing” case to the Coordination and Maintenance Committee as to why the codes can’t wait for the next regularly scheduled update, such as the emergence of a new disease—criteria similar to that used for April ICD-9-CM updates should be employed; as with the April update process, CMS and NCHS would have the final authority in determining whether a sufficiently “clear and convincing” case was made to warrant the establishment of a new code during the code set freeze period).
- If an urgent ICD-9-CM code proposal is approved for FY 2013, a corresponding change should immediately be made to ICD-10-CM/PCS to ensure these code sets include the most recent ICD-9-CM updates at the time of implementation.
- During the freeze period, CMS and NCHS should be allowed the flexibility to correct errors identified in the ICD-10-CM/PCS code sets, such as incorrect index entries or incorrect code references in instructional notes.
- Updates to the ICD-9-CM and ICD-10-CM/PCS guidelines should be frozen for the same years as the code sets, except for changes necessitated by the implementation of the urgent codes noted above.
- CMS should announce the proposed code set freeze date in the FY 2011 hospital inpatient prospective payment system proposed rule.
- The Coordination and Maintenance Committee should continue to meet during the code set freeze period in order to consider ICD-10-CM/PCS code proposals and avoid a backlog of proposals in spring 2014. CMS and NCHS should consider posting “working draft addenda” during this time to keep the industry apprised of code changes slated to go into effect for FY 2015.
- ICD-10-CM/PCS code proposals should be included on the Coordination and Maintenance Committee agenda (starting in 2010) so that there is an opportunity for public discussion and input.

### **Why should both ICD-9-CM and ICD-10-CM/PCS code sets be frozen prior to ICD-10-CM/PCS implementation?**

#### **a. General**

- If only ICD-10-CM/PCS are frozen, then new procedures/technology could be added to ICD-9-CM and not ICD-10-CM/PCS, possibly resulting in new codes not being available in ICD-10-CM/PCS when implemented.
- ICD-9-CM shouldn’t be more up-to-date than ICD-10-CM/PCS.
- Ongoing updates to all three code sets (ICD-9-CM, ICD-10-CM, and ICD-10-PCS) during the ICD-10-CM/PCS transition would be burdensome on both the federal government (who is both responsible for maintenance of the code sets as well as implementation of ICD-10-CM/PCS as a payer) and the healthcare industry.
- Stable code sets during the time period when systems, policies, reports, and so forth are being converted to ICD-10-CM/PCS would reduce the cost, time, and complexity of ICD-10-CM/PCS implementation.
- Since ICD-9-CM is running out of space, freezing it such that no updates are made for the final year before ICD-10-CM/PCS implementation would have little adverse impact.

- All resources and time will be stretched to the limit by the ICD-10-CM/PCS transition, and even small changes will complicate the process of migrating to ICD-10-CM/PCS.
- Making no ICD-9-CM or ICD-10-CM/PCS code modifications for FY 2013 or FY 2014 would limit the amount of “re-work” needed to update ICD-10-CM/PCS modifications to reports, systems, policies, databases, and so forth that have already been made.
- Updates to the code sets are likely to slow down as ICD-10-CM/PCS implementation approaches. The space capacity issues in ICD-9-CM will continue to worsen, limiting its ability to be updated as the date of ICD-10-CM/PCS implementation approaches. Many suggestions for modifications to the ICD-10-CM/PCS code sets likely won’t arise until they have begun to be used— – many of the annual ICD-10-CM/PCS changes in recent years are due to ICD-9-CM updates.

**b. Systems and Vendors**

- Freezing the code sets would allow adequate time for systems and vendors to develop or modify software and conduct testing of systems to assure the systems are ready by October 1, 2013.
- It would simplify the implementation process and allow time for system stability before additional changes are introduced.
- It would provide the opportunity to test system interfaces with third parties or other dependent interfaces without the complexity of changing code sets.
- It would add cost to the ICD-10-CM/PCS transition for vendors and payers to have to contend with code set changes while completing implementation preparation and testing.

**c. Resources and Training/Education**

- Ongoing code set modifications during the final, intensive preparation for ICD-10-CM/PCS implementation will unnecessarily complicate the transition process and jeopardize vendor-readiness and the success of ICD-10-CM/PCS education.
- A freeze of the code sets ensures that as users began to learn the new code sets, no additional information (codes) would be added requiring them to go back and try and determine what has been added so they can make sure to learn the new material.
- A freeze ensures the availability of up-to-date coding products, educational materials, and other resources for the intensive coder training period and final ICD-10-CM/PCS implementation phase.
- There would be sufficient time to update ICD-10-CM/PCS resources (guidelines, GEMs, training materials, and so forth) without adding the cost of needing to update the materials to reflect additional code set changes.

**d. Reimbursement**

- Freezing the code sets will allow sufficient time for payment systems, medical policies, and payer contracts to be converted to the ICD-10-CM/PCS code sets prior to implementation, without requiring expensive, labor-intensive “re-work” to review and potentially revise systems and policies that have already been converted to ICD-10-CM/PCS in order to address new updates to the code sets.

- It will allow payers to focus on changes to payment systems, medical policies, and contracts necessitated by the transition to ICD-10-CM/PCS without also expending resources to make changes necessitated by ICD-9-CM updates.

#### **What are the disadvantages of freezing the code sets?**

- There will be a lag in matching industry practices to the classification system, between the development of new technologies, services, and procedures and the creation of new codes for them, and between WHO updates to ICD-10 and their incorporation into ICD-10-CM. However, skipping the FY 2013 and FY 2014 ICD-10-CM/PCS updates would strike an acceptable balance between minimizing the lag time for new codes and the need for stable code sets during the final stages of ICD-10-CM/PCS implementation. As noted above, a process could be implemented to allow for urgently needed codes.

#### **Why should the last update (until after ICD-10-CM/PCS implementation) to ICD-9-CM and ICD-10-CM/PCS be FY 2012?**

- Unstable (meaning “still undergoing modifications”) ICD-10-CM/PCS code sets one year prior to implementation would significantly add to the cost and complexity of finalizing system and other changes, testing, and other implementation activities occurring in the final phases prior to the ICD-10-CM/PCS compliance date.
- Since the ability of ICD-9-CM to meet demands for clinically accurate and detailed healthcare data continues to decline each year, omitting the ICD-9-CM update for the last year of its use would not dramatically affect the quality of US healthcare data.
- Systems would be kept as up-to-date as possible, while allowing them to be frozen just in time for intensive coder education.
- It allows sufficient time for the conversion of the Medicare MS-DRG system to be finalized, including adequate time for the industry to review and comment on the MS-DRG conversion.
- It allows time for downstream impact such as billing edits, local coverage determinations, and so forth to be rewritten and tested.
- It provides stable code sets for an adequate period prior to the ICD-10-CM/PCS transition to allow the federal government and healthcare industry to focus on preparation, data analysis and transition to the new code sets.
- It allows time for the industry to complete final preparation prior to October 1, 2013 without having to contend with the annual update(s) for the last year prior to implementation.
- It allows for freezing of the code sets before the intense coder education begins.
- It allows accurate, up-to-date training materials necessary for coder education to be completed without the additional expense of updating the materials to reflect new code set changes or the risk of the materials being outdated or inaccurate if they are not revised.
- Due to the number of changes organizations will need to make for the ICD-10-CM/PCS transition, many changes to systems applications and databases, system logic and edits, forms, reports, payer medical and reimbursement policies, payer contracts, and so forth will have already been made by this time, so any modifications to the code sets at this point would

require significant additional cost and time (to go back through all of the systems, policies, and processes already converted to ICD-10-CM/PCS; determine which ones are impacted by the new code set modifications; and make the additional necessary changes).

- Some healthcare organizations and vendors may choose to delay making systems modifications until the code sets are “stable”; if code set updates still occurred for FY 2013, and organizations waited until after this update to make systems changes, they likely would not have sufficient time to complete the necessary modifications and testing before the October 1, 2013 compliance date.
- Ongoing code set modifications could complicate the testing process by making it more difficult to pinpoint the source of problems encountered during the testing process.

### **Why should the code set freeze date be established in the FY 2011 hospital inpatient prospective payment system rulemaking cycle?**

- If CMS announces a freeze date as soon as possible, the healthcare industry still has time to submit code proposals for consideration for the FY 2012 update cycle.
- It allows the opportunity for all stakeholders to understand the expectations for the transition and to modify their schedules accordingly as they prepare for the ICD-10-CM/PCS transition.
- The sooner feedback is received and the notice is provided, the better prepared the industry is for the change.
- It is necessary to alert industry stakeholders of the freeze date so they are spurred to submit any code proposals they would like to see implemented prior to the transition to ICD-10-CM/PCS soon.
- It will provide the industry with as much advance notice as possible so their ICD-10-CM/PCS planning and preparation processes and timeline can take the code set freeze into consideration.
- It will provide reassurance that the code sets will not be constantly changed up to the last minute and so that the reimbursement systems can be finalized and the MS-DRGs weighted appropriately in plenty of time for the FY 2014 hospital inpatient PPS final rule (if everyone, including CMS, thinks that coding changes can still occur up to the last minute, payers and others may hold off making the necessary changes until later, which could lead to errors or inability to be ready by the compliance date).

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<sup>i</sup> “Fiscal Year” throughout this document refers to the Federal government’s fiscal year, which begins on October 1.