



1730 M Street, NW, Suite 502
Washington, DC 20036

phone » (202) 659-9440
fax » (202) 659-9422
web » www.ahima.org

October 20, 2008

Michael O. Leavitt
Secretary
US Department of Health and Human Services
c/o Centers for Medicare and Medicaid Services
Attention: **CMS-0013-P**
PO Box 8016
Baltimore, Maryland 21244-8016

RE: File Code CMS-0013-P

Dear Secretary Leavitt:

The American Health Information Management Association (AHIMA) congratulates you and the Department of Health and Human Services (HHS) on the Notice of Proposed Rulemaking (NPRM) for the adoption of ICD-10-CM and ICD-10-PCS, as published in the August 22, 2008 *Federal Register* (CMS-0013-P). AHIMA welcomes the opportunity to provide comments on these long-awaited proposed regulations.

AHIMA is an 80-year old, nonprofit, professional association representing more than 52,000 health information management (HIM) professionals who work throughout the various segments of the healthcare industry. HIM professionals' work is integral with the diagnosis and procedure classification systems that serve to create the diagnosis related groups (DRG) discussed in this proposed rule, as well as a variety of internal and external uses including mortality and morbidity reporting.

While the ICD classifications are most often associated with reimbursement, in truth they have a significant role in furthering the value of electronic health records and a vital role in providing data for a variety of measurement, research, and policymaking decisions associated with healthcare quality measurement, disease management, patient safety, research, population health, and healthcare delivery reform. HIM professionals who work constantly to insure the integrity, uniformity, and consistency of health information and data see the adoption and final use of the ICD-10-CM and ICD-10-PCS as a giant step in the direction of increasing the utility of electronic health records and improving the individual and population health in the United States.

A part of our historic and ongoing effort to promote uniform and consistent coding practices AHIMA serves as one of the Cooperating Parties, along with the Centers for Medicare and Medicaid Services (CMS), the Center for Disease Control and Prevention's National Center for Health Statistics (NCHS), and the American Hospital Association (AHA). The Cooperating Parties oversee correct coding rules

associated with the *International Classification of Diseases Ninth Revision, Clinical Modification* (ICD-9-CM).

Based on the belief that quality information leads to quality healthcare (and by extension quality health) AHIMA has advocated for the United States to join the ranks of other developed nations and adopt a classification systems that combines contemporary medical and disease knowledge while remaining interoperable with the international classification systems adopted and recognized by the World Health Organization. AHIMA has taken an active role since 1993 in seeing the US government develop modern diagnoses and inpatient procedure classifications. AHIMA is active in national and international efforts to improve the terminology and classification systems that serve as the underlying structure for uniform electronic health records and healthcare data exchange. With this background and experience, **AHIMA applauds the development of these proposed rules and urges the Department and the healthcare industry not to lose momentum in completing the final adoption and use of ICD-10-CM and ICD-10-PCS.**

Our detailed comments on the proposed rule for the adoption of ICD-10-CM and ICD-10-PCS follow in order of their appearance in the August 22, 2008 NPRM.

I. Background (73FR49797)

The proposed rule notes that the secretary must provide instructions on how data elements encoded before any modification may be converted or translated, and references the data mapping between ICD-9-CM and ICD-10-CM and ICD-9-CM and ICD-10-PCS that has been developed. The NPRM also indicates these data maps are revised in the fall of each year. **AHIMA recommends that HHS inform the healthcare industry as to how long after ICD-10 implementation the data maps will continue to be updated annually.** Given ICD-10-CM and ICD-10-PCS will be updated at least annually after implementation, the data maps will likewise require updating to be accurate. The healthcare industry and users of healthcare data must understand how long these maps will be maintained and updated. **AHIMA recommends that HHS meet with the industry stakeholders and determine the optimum length of time these data maps will be updated and maintained until the full integration and use has been achieved.**

The road to US adoption of a replacement for ICD-9-CM began in 1993 with the National Committee on Vital and Health Statistics' (NCVHS') declaration that the (current) classification was broken. Since that time numerous delays have occurred, and even after replacement classifications were developed (by the late 1990s), other barriers were raised that prevented a potentially more economical implementation. This has not prevented various organizations to continually urge delay in spite of the fact that the cost of inevitable implementation raises the costs as time and the adoption of electronic health systems moves forward. Meanwhile, the delay in adoption of a replacement for ICD-9-CM has not reduced the need for more detailed and explicit codes which now brings the nation to a point where few codes are left and any alternative will have a negative affect on the integrity and use of the data collected.

Today, we face the same concerns regarding time and costs associated with adoption and implementation. Fortunately, we are no longer faced with debate over the need for advancing to the contemporary classifications. Our healthcare systems, for quality measurement, patient safety, public health and biosurveillance, research, and claims adjudication all call out for the detail ICD-10-CM and

ICD-10-PCS can provide, but after one delay and then another, the timing and implementation of the code sets is again challenged, even as the cost of implementing these changes rises exponentially with the increase adoption of electronic health records and other healthcare systems. Had the US implemented ICD-10-CM and ICD-10-PCS 5, 8, or 10 years ago, the costs and impact on resources and time would have been significantly less.

AHIMA urges HHS not to ignore the cost of implementation and its impact, especially on some financially burdened segments of the industry, but HHS must also to act on the knowledge that further, unsupported delay will increase the cost of implementation, diminish the value of the data collected with the ICD-9-CM classification system, and increase its negative impact on the healthcare systems and health of this nation.

II. ICD-9-CM (73FR49798)

The proposed rule provides a good description of the current classification system, ICD-9-CM, as well as the maintenance and updating process and the classification system's impact on the Medicare Hospital Inpatient Prospective Payment System (IPPS). It is important to note that while ICD-9-CM was incorporated into the PPS system in 1983, its original purpose was not for reimbursement, but rather a means to provide information from health records that could be used for a variety of health system management, research, and population health purposes. Many stakeholders and groups consider ICD-9-CM as only a subset of Medicare and other healthcare reimbursement systems and ignore the original intent and other use of this classification system. With such an assumption, we expect that many comments will be critical of this proposed rule and reviewers will fail to recognize or comment on how to address the limitations now affecting the non-reimbursement purposes of these classification systems such as public health reporting, biosurveillance, research, quality or outcomes assessment, and policy making. **We urge HHS to continue its pursuit of adoption of the ICD-10-based classification so that all healthcare data users will have precise and contemporary information.**

Similarly, HHS provides little information on how the adoption of ICD-10-CM and ICD-10-PCS will immediately affect the existing DRG and other Medicare prospective payment programs, especially given the effective date coincides with the beginning of a new Federal fiscal year. While we recognize that such reimbursement-based notification would normally come from the CMS as opposed to HHS, **we suggest that either HHS comment on how the PPS programs will be initially affected by the change in classification systems, or have a CMS notice provide such information for healthcare industry education.** AHIMA is concerned that if healthcare providers believe their PPS or other payment systems will be immediately affected and modified on the compliance date, for ICD-10-CM and ICD-10-PCS classification, they will object to the adoption of these classification systems.

III. Limitations of ICD-9-CM (73FR49799)

ICD-9-CM is clearly nearing the end of its useful life. The NCVHS recognized the need to replace ICD-9-CM over 15 years ago, and its failure to meet modern healthcare data requirements has worsened. Not only is ICD-9-CM not designed to provide the level of detail necessary and demanded for today's healthcare environment, its functionality has been exhausted by efforts to continue to add codes to describe new procedures and diagnoses. Requests for 21st century codes come continually from CMS and leading medical professional groups and technology developers. All are desirous of maintaining US leadership in healthcare research, knowledge, and practice. Unfortunately, many vital

requests have been denied because of the limitations described in the NPRM. Continued use of codes that cannot reflect current clinical knowledge, technology, and practice severely restricts the reliability and validity of our national healthcare data. As the healthcare industry continues to make innovative strides, the information gap continues to widen at an exponential pace.

We concur with the categories of ICD-9-CM limitations outlined in the proposed rule. The space limitations in ICD-9-CM have become critical, highlighting the urgency with which we need to implement the ICD-10 code sets. The ambiguity in ICD-9-CM and the use of outdated terminology that does not correspond to physician documentation makes ICD-9-CM, confusing, difficult to use, and open to misinterpretation, resulting in decreased coding accuracy and productivity while increasing allegations of “abuse” or fraud.

We must note that concern was raised that the more detailed ICD-10-CM and PCS classification systems might lead to more “abuse” in the practice of coding. The reverse is true, since with more specific codes a professional coder or encoder system can scrutinize the documentation and have a clearer picture of which code to choose since the new codes are more specific to the documentation and 21st century clinical practice.

AHIMA agrees that the impact of workarounds, such as creating new codes in unrelated sections or chapters, has adversely impacted the hierarchical structure of the ICD-9-CM procedure code set. Workarounds are not a long-term solution to the problems with ICD-9-CM, and they do not serve as a reasonable mechanism for maintaining ICD-9-CM in a logical manner for maximum use. The workarounds suggested, if accepted, could cause the United States to have a jumble of unusable healthcare data for the period between now and when the new ICD-10-CM and PCS classifications are in place.

We agree that in an age of electronic health records (EHRs), it doesn't make sense to use a coding system that lacks specificity and does not lend itself well to updates. As noted in the proposed rule, emerging healthcare technologies and the need for interoperability amid the increase in adoption of EHRs and personal health records (PHRs) require a standard code set that is expandable and sufficiently detailed to enable the accurate capture of current and future healthcare information.

As HHS reviews all comments received in response to the proposed rule and considers the implementation timeline to be published in the final rule, AHIMA urges HHS to consider that **ICD-9-CM simply cannot survive much more delay in its replacement. While a number of individuals and groups have vociferously called for continuing the use of ICD-9-CM over the last decade, they have not provided a reasonable means or justification to address the significant limitations of the code set and the impact of these limitations. AHIMA urges HHS not to take any steps that will create some of the problems cited above and in the NPRM and will further lessen the value of our current classification-based information.**

IV. ICD-10 and the Development of ICD-10-CM and PCS (73FR49800)

ICD-10-CM and ICD-10-PCS have been under development, testing, refinement, and updating by HHS agencies since the mid-1990s. As noted in the NPRM, these classification systems were developed with significant input from the medical community and the overall healthcare industry. ICD-10-CM and ICD-10-PCS provide specific diagnosis and treatment information that can improve

quality measurements and patient safety, the evaluation of medical processes and outcomes, and reflect 21st century medical and disease knowledge now incapable of being captured in the 30-year-old ICD-9-CM.

ICD-10-PCS has the capability to readily expand and capture rapidly developing new procedures and technologies. AHIMA expects that replacement of ICD-9-CM with ICD-10-CM and ICD-10-PCS would improve efficiencies and lower costs through:

- Increased use of automated tools to facilitate the coding process
- Decreased claims-associated submissions (attachments and further information requests) and claims adjudication costs
- Increased information that can justify quality and outcomes assessment
- Fewer rejected and improper reimbursement claims
- Decreased need for manual medical record documentation review
- Increased specificity in the area of disease and medical practice that cannot be described currently with ICD-9-CM codes (for example in behavior health)
- Reduced coding errors
- Reduced labor costs and increased productivity

The increased specificity of ICD-10-CM and ICD-10-PCS codes and the use of medical terminology that reflects the 21st century will make codes more efficient to assign than ICD-9-CM codes, resulting in improved coding accuracy and productivity. This increased specificity will also facilitate the development of more sophisticated automated coding tools (computer assisted coding) to assist with proper code selection, thereby improving coding accuracy and compliance with payment policies, and reducing the level of manual labor involved in the coding process.

A myth exists that adoption of ICD-10-CM will cause all users to access and utilize all 68,000 codes cited by HHS in the NPRM. HHS should provide more examples of how different providers will actually be affected by the code sets on a day-to-day basis. AHIMA has started this education process, but we are concerned that a lack of awareness of how the code sets are and will be used leads many to oppose change when they should be supporting change.

The anticipated benefits of electronic health records (EHRs) and a nationwide health information network cannot be fully realized without ICD-10-CM and ICD-10-PCS. True interoperability cannot be achieved without ICD-10 because ICD-10-CM and ICD-10-PCS are significantly better suited for use in EHR systems than ICD-9-CM. ICD-10-CM and ICD-10-PCS can be more effectively mapped to clinical terminologies (SNOMED-CT® for example) that serve as the basis of the EHR, their data are more easily retrievable in an electronic format, and they are more amenable to automated processes than ICD-9-CM.

Both ICD-10-CM and ICD-10-PCS have undergone testing, with very positive and encouraging results. Field testing of ICD-10-CM that involved the coding of 6,177 medical records in a variety of healthcare setting was conducted by AHIMA and the AHA. This testing revealed that ICD-10-CM codes can be applied to today's health records in a variety of healthcare settings without having to change documentation practices, although improved documentation would result in higher coding specificity, and therefore higher data quality, in some cases. Even with only two hours of training, the coders participating in this project did not find ICD-10-CM difficult to use. Although no documentation improvement strategies were employed as part of this project and coders were not

allowed to ask the physician for clarification, only 12.3 percent of the assigned ICD-10-CM codes fell in the category of “unspecified” codes.

For ICD-10-PCS, formal testing was conducted by CMS (then the Health Care Financing Administration (HCFA)) contractors and informal testing was conducted by AHA and AHIMA volunteers. The formal testing involved the coding of 5,000 medical records and an additional comparison test of 100 records. Participants received two days of training on the medical/surgical section of ICD-10-PCS and one day of training on the other sections. After the initial learning curve, participants were able to use ICD-10-PCS relatively easily. Testing results confirmed that ICD-10-PCS is more complete than ICD-9-CM, has much greater specificity, and the precision of ICD-10-PCS resulted in greater detail about the nature of the procedure. ICD-10-PCS is easier to teach because all the terms are defined and the standardized terminology makes it easier to use.

VI. Discussion of SNOMED-CT® (73FR49803)

We agree that SNOMED CT® is not a viable alternative to the adoption of ICD-10-CM/PCS because it is designed for distinctly different purposes and not for use in administrative transactions. Use of SNOMED-CT, even if it could be used for administrative purposes, would also require considerable investment in, and compliant use of, uniform EHRs by all healthcare providers, which we believe cannot be accomplished in a reasonable amount of time with the current adoption rate of EHRs and standards. Nevertheless, while SNOMED-CT cannot substitute for ICD-10-CM/PCS, the US needs the adoption of both SNOMED-CT and ICD-10-CM/PCS if it is going to have a solid and complete system of electronic health records and an integrated and comprehensive level of health data exchange as envisioned by the current work of the American Health Information Community (AHIC) and HHS.

VII. Alternatives to Adopting ICD-10 Code Sets (73FR49804)

VII-A. Utilize Unassigned Codes (73FR49804)

Utilization of unassigned codes is not a viable alternative to the adoption of ICD-10-CM/PCS because it does not address the problems with ICD-9-CM and does not improve the quality or integrity of healthcare data. In fact, it would contribute to the continued deterioration of data quality through further breakdowns in the structure of the ICD-9-CM code set. It would also result in significant costs for both HHS and the healthcare industry, in terms of increased complexity of maintaining and using the coding system, declines in coding productivity and accuracy, faulty conclusions or decisions based on inaccurate or incomplete data, and reimbursement errors.

AHIMA agrees with the HHS—the US needs to change to a new code set before ICD-9-CM becomes unworkable and unmanageable... a day that is fast approaching The two open series of codes CMS began using for new procedures and technologies will soon be exhausted. It is projected that the ICD-9-CM procedure coding system may run out of codes as early as 2009, and there is no feasible solution for continuing to update the procedure codes once this happens. **AHIMA believes using any unassigned code in any chapter for any type of procedure is an unacceptable solution for continuing to create new procedure codes, once the two open series of codes have been depleted.** This approach would severely disrupt the ICD-9-CM structure (completely alter the meaning of chapters, sections, and categories), and lead to significant coding errors and inaccurate data trending. For instance, when conducting database searches, it is a common practice to use code ranges

to identify classes of procedures or diagnoses. Use of unassigned codes for any diagnosis or procedure will therefore severely hamper health data research activities, which are key to many recently enacted quality and patient safety programs.

As a classification system, ICD-9-CM's hierarchical structure assists in defining coding concepts by placing them into organized, distinct groupings. Therefore, titles of chapters, categories, and subcategories would have to be changed to accommodate procedures that don't fit in the hierarchy. For example, Chapter 1 is Operations on the Nervous System, category 01 in this chapter is titled "Incision and excision of skull, brain, and cerebral meninges," and subcategory 01.3 is titled "Incision of brain and cerebral meninges." To use an unassigned code in subcategory 01.3 for an unrelated procedure (such as a cardiovascular procedure) would require titling the chapter category 01 and subcategory 01.3 to indicate that procedures other than those on the brain and meninges, and perhaps procedures in a different body system, are also included in this category and subcategory. Also, there are currently many instructional notes at the category and subcategory level requiring revision because they would not be applicable to new codes unrelated to the other codes in the category or subcategory.

Disruption of the hierarchical structure will occur if the ICD-9-CM diagnosis coding system uses unassigned codes in a given category to identify conditions unrelated to other codes in that category. This is not a permissible means of expanding the existing coding system because ICD-9-CM diagnosis codes are based on the World Health Organization's ICD-9, and must be consistent with the established international structure. Although the space limitations in the ICD-9-CM diagnosis codes have not been as critical as in the procedure codes, there have been space issues resulting in the location of related codes in different sections. For example, some acquired "absence of organ" codes are located in subcategory V45.7, whereas others are located in newly created category V88 due to lack of space in V45.7.

VII-B. Use CPT-4® for Coding Hospital Inpatient Procedures (73FR49804)

CPT-4 should not replace the ICD-9-CM procedure code set, as it is not designed to meet procedure reporting requirements in the hospital inpatient setting. ICD-10-PCS was developed specifically for reporting hospital inpatient procedures. As noted in the proposed rule, a Government Accountability Office (GAO) report stated that CPT has not been shown to be acceptable or comprehensive enough to serve as a single procedure code set for reporting both hospital inpatient and outpatient physician services, therefore, the GAO did not recommend the use of CPT to capture inpatient services. It must be noted, however, that a myth is circulating at the present time suggesting the CPT coding system will be eliminated as a physician billing and quality measurement tool with the adoption of these proposed rules. We believe that HHS must reiterate that this is not the case and challenge other suggestions that physician practices will be required to use a significant increased number of codes with the change to ICD-10-CM. These myths are causing a backlash against the proposed rule.

VII-C. Wait and Adopt ICD-11 (73FR49805)

AHIMA does not support waiting for the adoption of ICD-11. ICD-11 is not a viable alternative in as much as work on the design has barely begun and the completion timeframe is still unknown. ICD-10-CM, not ICD-9-CM, is the pathway to ICD-11 as the structure of ICD-11 is committed to be built upon the same data structure as ICD-10. Failure to accommodate ICD-10-CM in various healthcare clinical and administrative systems applications means substantial higher costs for conversion later. ICD-11 also does not address procedure code reporting, which is a significant problem.

The earliest projected date for implementation of ICD-11 is a decade away and optimistic forecasts note an even longer period if there is a need to develop a clinical modification for use in the US. ICD-9-CM absolutely must be replaced as soon as possible. Conversion to ICD-10-CM will address many of the current problems and limitations associated with ICD-9-CM and provide a much easier and quicker means for adoption and implementation of ICD-11 once the time comes.

VIII. Provisions of the Proposed Regulation (73FR49805)

VIII-C. Proposed Compliance Dates (73FR49805)

The US needs to transition to the ICD-10 code sets before ICD-9-CM becomes unworkable. As noted in earlier comments, the workarounds employed over the last few years to address the space limitations in ICD-9-CM will fail to be a reasonable approach to extending the life of ICD-9-CM.

ICD-9-CM is 30 years old and the need to replace it was identified 15 years ago, when NCVHS expressed concern that ICD-9-CM might be stressed to the point where the quality and the integrity of the system would be compromised. Never in US history has the same version of an ICD classification been used for 30 years. The US requires complete and accurate healthcare data more than ever as it faces serious challenges related to quality of care, patient safety, biosurveillance monitoring, research leadership, and healthcare reform. If we cannot rely on our healthcare data, if we cannot exchange health information and maintain the integrity of the clinician and patient's record – what then?

AHIMA agrees the enhanced functionality that ICD-10 code sets bring to quality assessment, disease management, continuity of care, research, and biosurveillance argue for implementing sooner rather than later. ICD-10-PCS provides an enhanced ability for reporting on the use of advance technologies and procedures. ICD-10-PCS can also report on certain drug, blood components and other substances, and therefore, could serve as a better alternative to using National Drug Codes or other alternative coding systems.

While AHIMA recognizes that the proposed rule only addresses the use of the ICD-10 code sets in HIPAA transactions, the healthcare industry needs to be aware of how these code sets will be used for non-HIPAA data reporting requirements in order to prepare for ICD-10 implementation. For example, home health agencies are currently required to report ICD-9-CM procedure codes on the home health plan of care (to identify surgeries performed during the preceding hospitalization). So, while home health agencies do not need to use ICD-10-PCS codes for HIPAA transactions, they may need to use this code set in the plan of care. CMS needs to communicate to the home health industry as soon as possible whether the requirement for reporting procedure code information on the plan of care will be changed, or whether home health agencies will be expected to report ICD-10-PCS codes on the plan of care. Similarly other healthcare sectors currently use the ICD-9-CM procedure codes for non-HIPAA transactions. The use of ICD-10-PCS codes on the plan of care will increase ICD-10-PCS training costs. If ICD-10-CM and ICD-10-PCS will replace ICD-9-CM code reporting requirements for these non-HIPAA transactions, this will also impact some implementation processes and costs, but then the additional detail ICD-10-PCS provides will prove a valuable benefit.

In addition to the use of the codes for HIPAA transactions, as noted in the rule, healthcare providers and plans need to communicate and determine non-HIPAA reporting requirements for public health, oversight reporting, and so forth. Early recognition of these requirements can significantly improve the

analysis and implementation process and prevent later modifications. We also note that a number of patient health record (PHR) systems currently use ICD-9-CM codes as a substitute for diagnoses and procedure information taken directly from the provider health record. These systems will also need to be upgraded, but again the additional detail will be significantly more valuable to the users of these PHR products than the current vague and limited ICD-9-CM data set used in healthcare claims.

AHIMA completely supports a single compliance date, across the US healthcare industry, for ICD-10-CM and ICD-10-PCS. Allowing both ICD-9-CM and ICD-10-CM/PCS codes to be reported for the same date of service or period would cause increased errors, significant confusion, and an administrative burden for providers and potentially increase health risks for consumers or patients. Allowing both the ICD-9-CM and ICD-10-CM/PCS code sets to be used and reported concurrently would create confusion in processing and interpreting coded data. Maintaining both ICD-9-CM and ICD-10-CM will place a significant burden on providers. Providers would have to maintain both coding systems for a year because of different reporting requirements by some payers or entities if there were two implementation dates. Coders would be burdened by having to recall and apply codes from different coding systems for a year. It is much easier to simply learn and move to the new coding system for encounters occurring on a single fixed date. If entities were required to report and accept other coding systems for encounters occurring during a period of time, there would be significant system implication in trying to determine which coding system was being used to report the coded data. Allowing the reporting of codes from both the ICD-9-CM and ICD-10-CM/PCS codes sets for the same date of service would also result in data incomparability for the time period when both the old and new code sets are being used and further complicate data trending.

AHIMA agrees with HHS that upon publication of the proposed rule in the *Federal Register*, the industry should have actively initiated or completed planning for ICD-10 implementation. This is not the first “green light” HHS has given to the industry to start ICD-10 implementation plans and preparation. In the press release issued on October 2, 2007, announcing the CMS contract for an ICD-10 impact analysis, CMS stated “While we are still assessing the implementation and timing of the ICD-10, our proactive approach should send a signal to hospitals and other stakeholders who use the ICD-9 coding to begin making their own transition plans.” Similarly, HHS has noted its intention to address the replacement for ICD-9-CM in its semi-annual agenda published in the *Federal Register*, for some time. While signals have been given, there remains a sizable segment of the industry – providers, health plans, clearinghouses, and vendors that will continue to wait until a final rule is proclaimed and the effective date is reached. We further expect that groups will also besiege Congress for extensions as well. **AHIMA urges HHS to deliver a final rule as quickly as possible so that all segments of the industry are aware of and working toward a successful and uniform compliance.** The rule describes known HHS and industry HIT initiatives and their associated known or projected publication, delivery, or compliance dates. HHS comments that the projected compliance dates for these other initiatives have been sequenced in a manner allowing covered entities to concentrate their efforts on ICD-10 implementation. However, this timeline only takes known initiatives into consideration.

AHIMA agrees that the industry’s implementation and compliance with the adoption of ICD-10-CM and ICD-10-PCS, along with the companion implementation and adoption of the HIPAA-related transaction standards can be achieved if the environment in which they occur has a known and stable set of projects during the time between now and the final compliance date. **AHIMA urges HHS, Congress, and other healthcare organizations that can impact the implementation environment, to keep the implementation of the elements leading to compliance with ICD-10-CM/PCS in mind**

as they consider other changes over the implementation period. We know that there are many goals in mind for healthcare that can affect the resources needed for the ICD-10-related transition. Government and the healthcare industry must keep in mind; however, that conversion to ICD-10-CM and ICD-10-PCS will significantly benefit goals related to quality and patient safety, EHR adoption, electronic health exchange, coding-related reimbursement changes, and so forth.

With concern for adequate resources for ICD-10-CM/PCS and HIPAA related transaction standards upgrades, AHIMA notes the NPRM reference to the final rule and implementation of the HIPAA Claims Transaction. **AHIMA recommends that CMS continue to withhold the final rule for the HIPAA Claims Attachment Transaction until after the compliance date for ICD-10-CM and ICD-10-PCS and to re-evaluate the proposed standards used in the transaction in light of the rapid changes in standards related to the EHR and other clinical standards developed by Health Level Seven (HL7) in recent years.** The NPRM suggests that a final rule will be forthcoming related to the HIPAA Claims Attachment last proposed in September 2005. AHIMA believes that many current claims attachments are required due to the deficiencies of the ICD-9-CM classification system. We are also concerned that a number of organizations on more than one occasion have indicated to HHS and the industry that they firmly believed the implementation of the claims attachment transaction should not happen simultaneously with the implementation of ICD-10-CM and ICD-10-PCS. Initiating a final rule on attachments will provide another opportunity for a demand to delay implementation of ICD-10-CM and ICD-10-PCS and such a conflict should be avoided.

While the NPRM identifies the ICD-10-CM and ICD-10-PCS standards and how they can be found on the CMS and National Center for Health Statistics (NCHS), CDC Web sites, it fails to note that these standards have been available for some time and are updated on a periodic basis. The same situation exists for the transaction standards indicated for the HIPAA transactions. There is no reason that the entities covered under this rule cannot begin the analysis and implementation processes identified, since these standards are easily obtainable. **AHIMA also urges HHS and others in the healthcare industry to work with us to help the industry identify and work through the steps necessary to make the transition to ICD-10-CM and ICD-10-PCS.** This is a big task for some and the time to begin is now.

AHIMA also calls on HHS to accelerate the provision of a final rule for ICD-10 adoption and implementation of the companion HIPAA-related transaction standards upgrades. The proposed October 1, 2011 compliance date for ICD-10-CM and ICD-10-PCS fits with previous recommendations that AHIMA has made. However, our recommendation for such a date has been based on a projected three-year implementation period that includes both the HIPAA-related transactions upgrades (proposed in the August 22, 2008 *Federal Register* (73FR49742) and the ICD-10-CM and ICD-10-PCS implementation. We are concerned that the time period between closure of comments on a proposed rule and the final rule has been of such an extended duration in the past that many of those affected now tend to wait until the final rule is issued and, in the case of HIPAA rules, the additional sixty days have passed. The use of ICD-9-CM classification codes has permeated electronic clinical and administrative processes in a variety of different ways, and we are concerned that ample time be given for implementation and testing of all the changed standards. Assuming that implementation steps by affected entities will begin immediately, **AHIMA believes that a three-year implementation period should be provided beginning with the effective date and that the compliance date should be the immediate October 1 date after that three-year period.**

AHIMA recognizes the importance of ensuring a successful transition to ICD-10-CM and ICD-10-PCS, without any further delays or postponement as the expected compliance date approaches. We also recognize that some healthcare entities have concerns about the implementation timeline in the proposed rule. However, replacement of ICD-9-CM is long overdue and the US no longer has the luxury of extending the implementation timeline and delaying implementation for several more years. Implementation of ICD-10-CM and ICD-10-PCS has been delayed for 20 years already, resulting in higher implementation costs and reliance on healthcare data that are based on a broken and dysfunctional coding system. As time passes, implementation costs will continue to escalate, ICD-9-CM will become completely unworkable, resulting in an inability to create new codes to describe medical advances and new medical knowledge, and healthcare decisions will continue to be made that are based on increasingly unreliable and inaccurate coded data. For all of these reasons, **AHIMA urges HHS to issue a final rule for the implementation of ICD-10-CM and ICD-10-PCS before the end of this year and establish an ICD-10-CM and ICD-10-PCS implementation date that is no later than October 1, 2012.**

There has also been concern regarding the on-going updating of the classification systems. Just as ICD-9-CM has been up-dated essentially yearly, as part of the annual Medicare Inpatient PPS update (October 1), the ICD-10-CM and PCS classification have also been updated. However, to facilitate the transition and implementation to ICD-10-CM and PCS, **AHIMA recommends that ICD-9-CM, ICD-10-CM, and ICD-10-PCS code sets be frozen for one year prior to the compliance date.** For example if October 1, 2011 is the compliance date for ICD-10-CM and ICD-10-PCS, then no further modifications to the ICD-9-CM, ICD-10-CM, or ICD-10-PCS code sets should be made on or after October 1, 2010. While we prefer not to have the code sets frozen, we hear the concerns, especially from vendors, of the need to have a period when coding systems such as encoders can be finalized so that no modification has to be made in the months immediately preceding the compliance date. Such a freeze would also allow those being trained in the new systems to use and practice with the actual code set they will be using, this will add to instruction, learning, and potentially to less errors. It also means that instructional and actual coding products (most likely software) can also be designed and selected early without concern for a need to upgrade in the months immediately before the compliance date. We do not recommend freezing the code sets earlier than one year prior to implementation of ICD-10-CM and ICD-10-PCS because it is important to ensure the code sets are up-to-date at the time of implementation.

AHIMA welcomes the opportunity to work with HHS and the industry to provide outreach and education to the healthcare industry. As an association that values the quality and integrity of health information we are willing to work with any segment of the industry to ensure the understanding, planning, implementation, workflow, training, and other factors associated with moving our nation on a par with others using ICD-10. We have provided general ICD-10-CM and ICD-10-PCS educational programs and other resources for over 10 years. We have already begun investing in educational programs and training materials to provide comprehensive ICD-10-CM and ICD-10-PCS education for coding professionals and those who use coded data.

Again, **AHIMA urges HHS and the healthcare industry to adhere to the final ICD-10 implementation timeline once established.** Any delays after implementation begins will increase the implementation costs, including the need to retrain coders and retest systems if the compliance date is extended after training or testing have occurred. Various groups have been actively advocating against the implementation of ICD-10 classifications for over a decade. Now we face serious consequences

and expense for this continued delay of an inevitable adoption and implementation cannot be permitted to continue if we are to make this implementation as efficient and effective as possible.

AHIMA welcomes the federal government initiatives in moving adoption of ICD-10-CM and ICD-10-CPS forward, but the government's role cannot end with a final rule, as we have already alluded. **HHS must internally and externally provide leadership in the implementation process through industry education, the sharing of resources, and the management of government health plan and other programs that are affected and affect implementation of the proposed code sets and the accompanying HIPAA-related transaction code sets.** Along with other recommendations we have made in this letter, we also urge HHS to ensure state Medicaid and other federally related healthcare programs are given the resources, guidance, and appropriate finances to meet the compliance deadlines. As the largest single stakeholder only HHS can provide this leadership and support.

XI. Regulatory Impact Analysis (73FR49808)

XI-B. Anticipated Effects (73FR49809)

We agree that adopting ICD-10-CM and ICD-10-PCS is the only viable alternative that would meet the long-term coding needs of the healthcare industry and we concur with the three key issues that HHS has identified as necessitating the update from ICD-9-CM to ICD-10-CM and ICD-10-PCS. To delay adoption and implementation of these replacement code sets, places the US in an untenable situation with limited reliable data on which to achieve healthcare quality, patient safety, improved research processes, and other reimbursement and policymaking decisions that face our nation.

We further agree that the greater precision in the ICD-10-CM/PCS code sets will eventually lead to lower incidences of abuse. Expanded clinical detail and translating the terminology used in medical record documentation to terms with standardized definitions reduces coding ambiguity and misinterpretation, and thus improves coding accuracy and the ability to effectively audit claims. The increased specificity of the codes will make it easier to compare reported codes with clinical documentation, check for consistency between diagnosis and procedure codes, check for illogical combinations of diagnoses, and compare practice patterns across providers. The improved logic and increased specificity in ICD-10-CM and ICD-10-PCS will facilitate the development of sophisticated tools for detection of questionable patterns and suspected fraud.

AHIMA agrees with your statement that “for initiatives in the early stages of development, costs to implement ICD-9-CM now, with conversion to ICD-10 code sets later, could be avoided by direct conversion to ICD-10 code sets (and X12 version 5010 HIPAA transaction standards) concurrently with the initiatives.” **AHIMA continues to urge healthcare system vendors to incorporate the ICD-10-CM/PCS data fields and HIPAA-related transaction standards at the 5010 and D.0 level in all products rather than to have their customers face retroactive changes at a much higher cost in the next few years.** This NPRM for the adoption of ICD-10-CM and ICD-10-PCS should put vendors on notice that application and database products from this point forward should accommodate the eventual use of ICD-10-CM or ICD-10-PCS. Purchasers should not be forced to delay their purchases of administrative software, EHRs, and so forth in order to avoid future retrofitting of the required applications and data bases. Presumably, groups such as the Commission for Certification of Health Information Technology (CCHIT) will be able to place the ICD-10-CM and ICD-10-PCS requirements

in future roadmaps for criteria keyed to dates of compliance in the final rule. All these steps will potentially lower the cost of implementation.

While we generally agree with HHS' approach to ascertain the impact of conversion, we must note that the healthcare industry has hundreds of thousands of providers, health plans, and clearinghouses. Few of these entities are alike, and therefore implementation quoted costs fail to take into account the current adoption of electronic transaction standards and other health information technology. As noted, the cost of conversion will substantially increase the longer this transformation is delayed and especially as the healthcare industry moves toward use of EHRs, health information exchange and other initiatives. Similarly, we also note that in challenging HHS' impact description, naysayers have assumed effects on providers not reflective of the limited nature of today's electronic systems adoption and suggest that demands will be made to provide detailed diagnoses beyond existing requirements and the availability of clinical data in health records and other reporting documentation. We acknowledge that implementation will be costly. However, delays in the past have brought us to this point of data crash, and further delay will increase the cost for all concerned.

We believe that healthcare entities, both providers and health plans, will experience administrative savings when claims are adjudicated and quality assessed with the use of contemporary classification systems. The additional effort currently experienced in the claims processing and data collection functions comes from a lack of detail in diagnosis and inpatient procedure code that cannot describe levels of care, severity, location, and other factors. The extra administrative efforts and delays are further exacerbated by the fact that most transfer of this additional post claims data is on paper.

XI-B-6-a. Estimated Costs – Training (73FR49814)

The timing of training costs for coding professionals outlined in the proposed rule seems reasonable. **AHIMA does not recommend that intensive coder training occur more than six months prior to implementation of the ICD-10 code sets in order for coding professionals to retain what they learned by the time they start using these code sets.**

The projected amount of training for coders in both ICD-10-CM and ICD-10-PCS also seems reasonable (five days). However, for coders who only need ICD-10-CM training, (for example, physician practices that will continue to use CPT-4® not ICD-10-PCS) one to two days of training would likely be adequate. Since ICD-10-CM retains many similarities to ICD-9-CM, it is expected to be easier for experienced coding professionals to learn and become proficient. The participants in the ICD-10-CM field testing project sponsored by AHIMA and the AHA only received two hours of ICD-10-CM training and had very limited ICD-10-CM coding resources available to them, and yet their coding accuracy rate was surprisingly high (79 percent).

The estimated number of full-time hospital coders in the proposed rule (50,000) is based on the total number of AHIMA members. This is not an accurate estimate, since not all AHIMA members are professional coders, not all coders are AHIMA members, and not all AHIMA members who are professional coders work in hospitals. We recognize that estimating the number of coders in the US is very difficult. Current statistics for occupational classifications also do not permit a fully accurate estimate of the number of coders. We do not have an estimate of the number of full-time inpatient hospital coders, but we want to point out that the basis for the figure in the proposed rule was flawed.

HHS' estimate that code users would require, on average, eight hours of ICD-10 training is reasonable. The category of "code users" represents individuals with a wide variety of roles and responsibilities, so the level of training needed would depend on how and to what extent the individual health professional use coded data and potentially how the training is delivered.

We agree that most physicians would not require or desire ICD-10 training. Many physicians rely on professional coding staff and/or the use of "superbills" or other tools that provide the most frequently-used codes for the physician's practice. For those physicians who do receive training, four hours of training is a reasonable estimate. And we also agree that at least some of this training is likely to be provided through existing physician continuing education mechanisms, including hospital-sponsored in-services, and county medical society programs.

XI-B-6-b. Estimated Costs – Productivity Losses (73FR49816)

AHIMA agrees that while some short-term productivity losses (up to six months) are to be expected while coding professionals and practitioners are becoming familiar with the new code sets, a permanent decline in productivity is not anticipated. More specific code descriptions and the use of consistent terminology should make the ICD-10 code sets easier to use than ICD-9-CM, once professionals have become familiar with them. This is supported by testing of ICD-10-CM and ICD-10-PCS. Also, since the ICD-10 code sets lend themselves to the use of computer-assisted coding technologies better than ICD-9-CM, we expect the development of increasingly sophisticated computerized tools will improve coding efficiency.

Initial short-term productivity declines are expected to be greater in the hospital inpatient setting than in other settings, since the coding professionals in this setting will need to learn ICD-10-PCS as well as ICD-10-CM. However, the degree of productivity loss is likely to be offset by the fact that the logical structure and standardized terminology in ICD-10-PCS make it easier to learn than ICD-9-CM.

It is not clear what the anticipated loss of productivity will be in a physician office. If the office uses the same coding process currently in place then for many practices the "super-bill" use should be about the same. Nothing is indicated from the NPRM or CMS that would signify any change in the level of coding required, but HHS would do well to let these practices know if any change is anticipated in the near future. Specialty practices will have new codes to use, However, given the specificity of ICD-10-CM, these codes should actually be easier to use than the vague classifications of today. As noted elsewhere, most of the changes between the international ICD-10 system and ICD-10-CM came about at the request of these specialty practices, and we believe they have the resources to support the changes identified in the NPRM.

XI-B-6-C. Estimated Costs of Systems Changes (73FR49818)

AHIMA does not possess the knowledge of the variety of systems and systems users to provide comments on the estimated costs. We can only reiterate that cost will not decrease, but rather increase if delays are added to the time it takes to make the changes necessary to accommodate ICD-10-CM and ICD-10-PCS. We agree with HHS that there is no way to avoid this inevitable change and the sooner it is accomplished the better. As we have noted elsewhere, there are a number of steps that HHS can take to make its experience with the HIPAA-related transaction standards and the ICD-10-CM/PCS adoption available to the healthcare industry and thus keep some costs reduced. From our experience in recent ICD-9-CM Coordination and Maintenance Committee meetings, we are also

aware that HHS and CMS will also be providing additional resources related to the “mapping” or crosswalk between ICD-9 and ICD-10 that will benefit the industry.

XI-B-7. Projected Benefits (73FR49821)

AHIMA concurs with the six benefits of transitioning to ICD-10 and believes the following are additional benefits:

- Better quality information and data in general to increase knowledge and eliminate errors and improve patient safety due to currently vague code options
- Better understanding of the individual’s disease, severity, and other clinical factors
- Better measurement of the quality, safety, and efficacy of care
- Improved research for treatment options and other population health data
- Improved payment systems and processing claims for more accurate reimbursement and alignment with quality
- Improved research, epidemiological studies, and clinical trials
- Improved health policy setting and use of more detailed data for better actuarial processes
- Better operational and strategic planning and designing healthcare delivery systems
- Increased motivation for adoption of EHRs that can be integrated with coding systems
- Improved monitoring of resource utilization
- Improved clinical, financial, oversight, and administrative performance
- Improved PHRs based on claims diagnoses
- Better Prevention and detection healthcare fraud and abuse
- Improved tracking public health and risk management

The discussion of the benefit of “more accurate payments for new procedures” in the proposed rule seems to focus on Medicare payments. However, we believe this benefit applies to other payers and health plans as well, especially since they, in addition to consumers and employers, are demanding quality and outcomes measurement, improved patient safety, and more quality data. The use of these contemporary codes will also facilitate better care coordination and value-based payment systems. **It must be recognized, however, that while practitioners will, we believe, benefit significantly over time from the adoption of these code sets, some will encounter costs that must be recognized especially in the current environment of electronic conversion and other costs of providing care under tight reimbursement rules. Some assistance from the Federal government and health plans, even if it is a low cost or interest free loan, should be considered to facilitate a smooth conversion and allow for investment in better systems.**

XI-C. Alternatives Considered (73FR49826)

AHIMA agrees with HHS that adopting ICD-10-CM and ICD-10-PCS is the only viable alternative meeting the long-term coding needs of the healthcare industry, and this change must come now!

As noted in the proposed rule, there will be greater resource impacts on HIT initiatives if ICD-10 is delayed and more EHR systems require retrofitting. A delay in ICD-10 implementation will also result in increased costs to code users due to further declines in coding productivity and accuracy associated with a failing coding system. Until ICD-10 is implemented, the federal government’s costs of maintaining both the ICD-9 and ICD-10 code sets will also continue to be incurred.

XI-F. Conclusion (73FR49831)

AHIMA does not support HHS’ assertion that if ICD-10 is not implemented, ICD-9 codes could continue to be used. As noted in our earlier comments and by HHS’ own statements in the proposed rule, ICD-9-CM is nearing the end of its useful life and will soon be unworkable. Therefore, we do not believe it is accurate to state that ICD-9 codes could continue to be used if ICD-10 codes are not implemented without accepting the fact that US healthcare data will be inaccurate and inconsistent with our needs for improved health and an improved healthcare system.

Other Comments

AHIMA recommends that NCHS and CMS make no modifications to the ICD-9-CM, ICD-10-CM, or ICD-10-PCS classifications in the fiscal year prior to ICD-10 implementation. This will allow healthcare organizations to complete the final year of the ICD-10 implementation process without having to deal with new coding system modifications once the compliance date is met.. Annual modification of the ICD-10 code sets could resume (effective October 1) the year following implementation (compliance). This freeze provides stability going into the conversion and, in the immediate post-implementation period, allows proficiency to be gained in the use of the new systems without having to learn coding system changes.

On a similar note, **we recommend and request that HHS or CMS inform the healthcare industry, especially providers or any plans not to modify reimbursement systems at the time of conversion.** We understand this is HHS’ intent, but a public statement of such intent will relieve fears and provide more information for planning if minimal changes occur.

AHIMA also recommends that CMS eliminate the use of a coding behavioral offset with the implementation of ICD-10-CM and ICD-10-PCS. This behavioral offset has been applied to prospective payment system standardized payment amounts in recent years to eliminate the suggested effect of changes in coding or classification that do not reflect real changes in case mix. We do not believe it would be appropriate to use this offset to reduce prospective payment system payments in the years following ICD-10 implementation. As the industry learns to use ICD-10-CM/PCS and becomes increasingly proficient, providers shouldn’t be penalized for this proficiency. In order to fully realize the anticipated benefits of ICD-10-CM and ICD-10-PCS, providers shouldn’t be discouraged from improving their coding proficiency.

We further recommend that the hierarchical structure of ICD-9-CM not be further disrupted by assigning new procedure (or diagnosis) codes to the incorrect body system chapter. Once the miscellaneous chapters (chapters 00 and 17) are filled, if a new code cannot be assigned to the appropriate body system chapter, no new code should be created. The procedure for which a new code was requested should continue to be assigned to the most appropriate existing code until ICD-10-PCS is implemented. We believe that renaming body system chapters or category titles would cause an unacceptable disruption of the ICD-9-CM hierarchical structure, create significant confusion, and compromise data quality and integrity. We must preserve the fundamental elements of the ICD-9-CM coding system in order to maintain at least a minimal level of data quality until the system is replaced with the ICD-10 code sets.

In order to provide the industry with a basic, user-friendly electronic coding tool to facilitate transition planning and preparation, **AHIMA urges CMS and the National Center for Health Statistics (NCHS) to produce a CD, or similar product, containing the ICD-10-CM and ICD-10-PCS code sets immediately after a final rule is published. An updated CD should be made available annually as long as the code sets continue to be modified.**

Finally, AHIMA urges CMS to begin accepting and processing all reported diagnoses and procedure codes as soon as possible, but certainly by the time the ICD-10-related code sets are implemented. Realization of the full benefits of the rich detail contained in the ICD-10-related code sets depends on the ability to use all of the reported diagnostic and procedure codes. The number of diagnoses and procedure codes reported should not be controlled by previous paper claims limitations.

Conclusion

AHIMA appreciates the opportunity to comment on the NPRM for the adoption of ICD-10-CM and ICD-10-PCS. The ICD-9-CM classification system is broken and the US faced an impending situation where its healthcare data will not provide the health information absolutely necessary for a variety of daily functions as well as essential to meet the needs and challenges of a 21st century health system. As this country searches for ways to improve its quality of healthcare and meet the demand for more information for clinical care, population health, healthcare administration, and research, we cannot turn our backs on the importance of healthcare data. ICD-10-CM and ICD-10-PCS are crucial for any advancement in this nation's quest and further delay in adoption, implementation, and use should not be permitted.

AHIMA stands ready to work with HHS and the healthcare industry to prepare for ICD-10-CM and ICD-10-PCS implementation. We recognize that implementation is a significant step forward and will impact all providers, health plans, vendors, payers (employers and others), and consumers. If AHIMA can provide any further information, or if there are any questions or concerns in regard to this letter and its recommendations, please contact Sue Bowman, RHIA, CCS, AHIMA's director of coding policy and compliance at (312) 233-1115 or sue.bowman@ahima.org, or myself at (202) 659-9440 or dan.rode@ahima.org.

Sincerely,

Dan Rode, MBA, FHFMA
Vice President, Policy and Government Relations

CC: Sue Bowman, RHIA, CCS
Director, Coding Policy and Compliance