AHIMA Comments on the Nachimson Report
"The Impact of Implementing ICD-10 on Physician Practices and Clinical Laboratories"

On October 8, 2008, Nachimson Advisors, LLC, released a report titled "The Impact of Implementing ICD-10 on Physician Practices and Clinical Laboratories." The report has received considerable comment from the press and has served as the basis for many comments made to the Department of Health and Human Services (HHS) in response to proposed rules related to the adoption and implementation of ICD-10-CM and ICD-10-PCS and the upgrading of HIPAA-related transaction standards published by HHS on August 22, 2008. AHIMA has reviewed this report and has the following comments.

General Comments

The Nachimson report indicates that it would not discuss any of the arguments for or against the adoption of the new classification systems. However, neither does it address how the new classification system might benefit the practice of medical care and in turn improve the efficiencies and effectiveness of the administrative process associated with the care provided by physician practices or laboratories. Healthcare needs 21st-century classifications to represent the causes behind patients seeking medical care and the care that the patient received. If the classification systems can do this, then all of the administrative efforts that currently go into describing diagnoses and procedures associated with a medical encounter or a episode of care can be significantly improved and eliminate a myriad of manual or paper-based processes that follow the initial submission of a claim, report, or other document that currently uses the ICD-9-CM system and cannot describe today's medical conditions and care (procedures and technology).

The report also assumes that in the short course of the proposed implementation (essentially three years), every potential change related to using an improved classification system will be required. These changes are not called for in the August 22, 2008, HHS notices of proposed rule making, nor have other health plans indicated that any such requirements would be forthcoming as required by the compliance date. Essentially, the HHS proposal takes today's practice of documentation, coding, and claims and requires that a new classification system (larger field size and alpha-numeric characters versus numeric characters) be used in the same manner as currently used. For physician practices this would mean substituting the ICD-10-CM system for the ICD-9-CM system.

There is nothing in the regulation to indicate use of the additional detail available in ICD-10-CM will be required. In fact, the Centers for Medicare and Medicaid Services (CMS) have indicated that they plan to map or cross-index the received ICD-10-CM codes back to ICD-9-CM for adjudication purposes. AHIMA, in its October 21, 2008, comment letter, asked HHS or CMS to

make this intent more specific. Other health plans have indicated that they currently use only the first three digits of the ICD-9-CM code and have not announced any intention of using or requiring more detailed codes. CMS has also indicated that it will share its mapping software for other health plans use.

The report also ignores the adoption of electronic health records (EHRs) that impact and are impacted by the use of ICD-10-CM. Currently, there is an effort by government and in the industry to encourage healthcare providers to adopt the use of EHRs. Part of that goal is to allow information to be extracted and analyzed, both for the care of the individual and for information to be applied for a variety of population health purposes. EHRs capable of reporting via the ICD-10-CM classification system are envisioned to transform EHR data through the use of encoder software to produce the ICD-10-CM codes that represent the diagnostic information in the EHR.

The ICD-10-CM classification system was designed to work with the terminologies that serve as the basis of a modern EHR. Therefore, in the future, as additional detail is required for claims, quality measurement, patient safety, and so forth, the process of reporting via the ICD-10-CM classification can be handled electronically, not manually. However, it must also be noted that the August 22 proposed rules did not require, suggest, or eliminate the process of manual reporting or increase any record reporting requirements.

The practice of coding takes information from the medical or health record and translates it to codes that best represent what is contained in the record. Professional coders only report codes that classify the information in the record. The report suggests that documentation in the record is generally incomplete and does not describe the condition of the patient or the services rendered. If this is the case, then the entire industry should be pursuing the improvement of documentation, if for no other reason than to ensure the accuracy and integrity of health records and patient safety. There is nothing in the adoption of ICD-10-CM or the August 22 proposed rules that suggests a three-year requirement to significantly increase documentation in the healthcare record.

Specific Comments

Report: *There are significantly more codes in ICD-10-CM than ICD-9-CM, about five times as many ICD-10-CM codes.*

Response: An increased number of codes does not mean increased complexity in using the coding system. In fact, greater specificity means the correct code is easier to determine because there is less ambiguity. Also, when the seventh character that denotes initial encounter, subsequent encounter, and sequela in certain sections is excluded, the number of codes drops from approximately 68,000 to 37,000 ICD-10-CM codes. Remember, the increased detail was requested and supported by the medical community as the US clinical modification of ICD-10 was developed in the late 1990s.

Report: *The ICD-10-CM codes are significantly more detailed and granular, requiring more documentation to support. For example, diabetes mellitus codes are expanded to include the classification of the diabetes and the manifestation.*

Response: Both ICD-9-CM and ICD-10-CM contain codes for diabetes and their manifestations. In ICD-9-CM, a separate code must be assigned to identify the specific diabetic manifestation, whereas in ICD-10-CM, the manifestation is included in the diabetes code. So in ICD-9-CM two codes are required to identify the diabetes and the manifestation, whereas in ICD-10-CM only one code is required. But both coding systems require medical record documentation describing the type of diabetes and any associated manifestations. Documentation requirements for ICD-10-CM should actually be less burdensome than for ICD-9-CM because ICD-10-CM no longer distinguishes controlled versus uncontrolled diabetes. Currently, documentation often does not include this distinction, requiring coders to query the physician in order to assign the appropriate ICD-9-CM code. This requires additional time and potential delay in assigning an accurate code.

Diabetes is considered one of the top healthcare issues in the US. While the proposed rules do not change the current claims requirements for reporting diabetes, at some time in the future additional detail may be requested. ICD-10-CM provides the ability to supply this detail within the claims structure rather than separate reporting, which increases administrative costs. If the medical community determines that additional detail is needed, healthcare providers will need to report such information. ICD-10-CM will make this task more efficient and the detail will allow for more precise information.

Report: *Clinical and administrative staff will require significant time simply to learn about the new codes. As the new rule is not a simple substitution of one code set for another, the learning curve is expected to be quite steep for both clinicians and administrative staff, particularly for small- and medium-sized organizations that do not employ professional coders.*

Response: A 2003 field testing study conducted by AHIMA and the American Hospital Association demonstrated that people with previous ICD-9-CM experience can learn ICD-10-CM easily. While physician practices and laboratories don't necessarily employ professional coders, it is likely that they have someone who is familiar with ICD-9-CM. For someone familiar with ICD-9-CM, ICD-10-CM is not difficult to learn. Many suggest that someone must learn and be familiar with the entire classification system. While users need to be familiar with the structure of the coding system most practices will normally only use a small subset of the entire system, just as they do today.

Report: *Nachimson Advisors estimates the staff education and training costs associated with an ICD-10 mandate would range from $2,405 for a small practice to $46,280 for a large practice.*

Response: These figures seem excessive. AHIMA estimates that comprehensive ICD-10-CM training will require two days (16 hours). We do not presume that all staff in a physician practice would receive intensive ICD-10-CM training (certainly not all staff received formal ICD-9-CM

training). We also doubt that most physicians would want 12 hours of training, the amount of training indicated for providers in the report. We believe most physicians would want no more than four hours of training. We also believe that for many physicians, the limited amount of ICD-10-CM training they would receive would be obtained through existing venues, such as hospital-sponsored programs or regular medical society meetings, at little or no additional expense.

For practices employing professional coders, professional coder certification generally requires annual continuing education to maintain the coding credential. Therefore, ICD-10-CM training costs will be offset by the annual training coders would receive even in the absence of ICD-10-CM implementation. We also anticipate training will be available in a variety of media, including Web-based training, thereby reducing cost and lost work time.

Report: *Health plans may modify provider contracts to comply with the greater specificity required in the ICD-10 mandate and adjust payment terms accordingly. Coverage determinations may also be revised in accordance with new diagnostic codes and additional documentation required by a health plan to support a patient's treatment plan.… With a change to ICD-10-CM, it is expected that health plan payment amounts will be changing based on severity of diagnosis and changes in coverage.*

Response: While this argument has been raised for the past decade, there is nothing to show that this change will take place during the implementation period or even shortly thereafter. We anticipate that many payers will follow CMS's example and initially map the ICD-10-CM and ICD-10-PCS codes to existing payer policies without modifying the payment policies themselves in order to gather cost data with respect to the use of the ICD-10-CM and ICD-10-PCS codes after implementation and make appropriate payment changes based on actual data. Currently, health plans do not have detailed data to make the kinds of changes suggested, and as we noted above, the transition of healthcare reimbursement will be based on a number of factors, including the improvement and use of quality measurement data and other data anticipated from the adoption and use of EHRs. To suggest that all of these changes will occur during this time period ignores the gradual evolution occurring in the healthcare industry.

Report: *With a change to ICD-10-CM, it is expected that health plan payment amounts will be changing based on severity of diagnosis and change in coverage. Significant changes in reimbursement patterns will disrupt provider cash flow for a considerable period of time.*

Response: Again, there is nothing in the HHS proposal or in any of the comments from the health plans or other payers in the healthcare industry to suggest that reimbursement processes will immediately change with the initial use of ICD-10-CM. As we have noted, change in reimbursement formulas, contracts, and so forth cannot legitimately transpire without first having the data to substantiate these changes. It is true that accurate use of ICD-10-CM could provide information as to the severity of the patient. If this data is used in the development of payment or quality formulas, it could allow reimbursement to be made in recognition of the

patient's severity level or the level of care needed. This is something the medical profession has been seeking, but even with ICD-10-CM in place, it will take some time and experience to reach. It will not happen on day one, and we do not believe it will create the cash flow disruption presumed in the study.

Report: *With five times as many codes as the previous ICD iteration, an ICD-10 mandate would require significant changes to existing superbills and/or spur some practices to move to an electronic medical record (and absorb corresponding software costs). The Nachimson report estimates the changes-to-superbills costs associated with an ICD-10 mandate would range from $2,985 for a small practice to $99,500 for a large practice.*

Response: The process of converting superbills to ICD-10-CM is not difficult, time consuming, or expensive. AHIMA has demonstrated that today's superbill can be converted to ICD-10-CM in just a few hours and that they are no larger than existing superbills. It is not necessary, nor required in the HHS proposal, to list all of the specific codes available to describe a particular condition. That is not how superbills are constructed today. Existing superbills would be several pages long if all of the ICD-9-CM codes pertaining to a particular condition were listed. For example, current superbills generally may list one or two ICD-9-CM codes for diabetes mellitus, even though there are 40 possible choices (not including the separate codes to identify diabetic manifestations).

The movement toward adoption of EHRs is occurring with or without ICD-10. There are many benefits to having an EHR, one of which is the use of technology to facilitate the coding process. And if EHRs are implemented without an ICD-10 mandate, the cost of implementing ICD-10 will continue to increase because more systems will need to be modified.

Report: *Nachimson Advisors estimates the information technology (IT) costs associated with an ICD-10 mandate would range from $7,500 for a small practice to $100,000 for a large practice.*

Response: It is not clear how these figures are calculated. Most physician practices are typically small (below the 10-person level) and their costs will vary depending on the amount of electronic processing and records usage in the individual practice and the capabilities of their systems and systems vendors as well as that of any clearinghouse used. Regardless of the actual IT costs of conversion, the costs will only increase the longer ICD-10 implementation is delayed, as EHRs and other systems that will require modification in the future to support the inevitable ICD-10-CM code implementation are adopted and implemented. If ICD-10 had been implemented when available 10 years ago, the IT costs would have been less expensive than they are today and will be in the future. AHIMA has called for systems/software vendors to install the capabilities for use of the ASC X12, version 5010, and the NCPDP, version D.0, in all products from this time forward. If providers can purchase EHRs and other systems knowing that they will be capable of meeting the compliance date without additional expense in the future, costs for conversion will be considerably less.

Report: *The Nachimson report provides an example of postmenopausal osteoporosis and indicates that it would be difficult to code this condition in ICD-10-CM without information about whether the patient had a previous history of a pathological fracture.*

Response: It is not necessary to know whether the patient had a prior history of a pathological fracture when assigning the appropriate code for postmenopausal osteoporosis. The codes are distinguished by whether or not the patient has a current, not a previous, pathological fracture, and the documentation should indicate whether a current pathological fracture is present.

Report: *The report states that in ICD-10-CM, coma must be coded based on a coma scale and the documentation may not always provide the information to assign the appropriate coma scale code.*

Response: A note under the ICD-10-CM code for coma scale states, "These codes are intended primarily for trauma registry and research use but may be utilized by all users of the classification who wish to collect this information." Therefore, it is incorrect to suggest that the coma scale codes must be used by physician practices.

Report: *The ICD-9-CM codes (for obstetrics) are organized by episode of care, the ICD-10-CM codes by stage of pregnancy. It would be necessary to completely rewrite documentation or at least change prospectively how documentation is organized.*

Response: The change in the ICD-10-CM codes to identify stage of pregnancy was requested by the physician community because it was felt to be more clinically significant than the episode of care. We believe that physicians who treat maternity patients typically document the trimester.

Report: *With the increased granularity of the ICD-10-CM codes, additional documentation must be provided to support the patient's diagnoses. Nachimson Advisors estimates the increased documentation costs associated with an ICD-10 mandate would range from $44,000 for a small practice to $1.76 million for a large practice. …it is expected the more specific codes will be required so more specific documentation is necessary.*

Response: AHIMA finds these cost estimates incomprehensible. We believe no cost (or very little cost) should be associated specifically with the need for increased documentation. This belief is supported by the 2003 AHIMA/AHA field test study, which demonstrated that ICD-10-CM codes can be assigned to today's medical records in all healthcare settings, including physician practices, without any changes in documentation practices. Just as in ICD-9-CM, there are "unspecified" codes in ICD-10-CM for those instances when medical record documentation is not available to support more specific codes. Of course, the benefits of ICD-10-CM cannot be fully realized if non-specific codes are used rather than taking advantage of the specificity in ICD-10-CM. However, in the AHA/AHIMA field testing study, only about 12 percent of the codes assigned were in the "unspecified" category, even though no changes to medical record documentation practices were made as part of the study. The increased specificity in ICD-10-CM

was requested by the medical community in order to reflect current medical knowledge. While we believe the healthcare industry will eventually migrate to more specificity, as we have indicated, there is no requirement to do so now or in the proposed rule.

There is no reason to expect that CMS and other payers would prohibit the use of non-specific codes and require that only the more specific codes be reported. In fact, AHIMA would oppose such a movement. Use of non-specific codes is not limited to instances when the documentation is insufficient. There are valid circumstances when non-specific codes are appropriate, such as when the clinician is unable to clinically determine the detail about a condition that would warrant a more specific code.

Report: *The increased documentation requirements would increase the amount of time and effort that practices spend on each patient encounter. This is not simply the temporary decrease in productivity due to learning a new code set. This increase would be permanent and could either require additional staff to provide the documentation or decrease the number of patients a practice could treat. These would increase costs and decrease revenues.*

Response: We do not believe the documentation improvement efforts to support ICD-10-CM coding will require a permanent increase in the amount of time and effort spent on documentation. The increased specificity in ICD-10-CM is based on requests from the medical community to make the coding system reflective of modern medicine. Requirements for improved documentation are not coming from the change to ICD-10-CM. Rather, improved documentation is necessitated by a number of industry-wide initiatives, including quality measurement reporting, patient safety, and value-based purchasing. Once better documentation becomes the standard of practice, it should not require ongoing additional time and effort especially as EHRs and other technical support improvements are also emerging to support the documentation process. Also, adoption of EHRs will facilitate documentation capture. Unfortunately, there is nothing in this study that provides an in-depth look at today's physician documentation, so we do not have any sense of the gap between what occurs in a patient encounter and what is actually documented.

Report: *The codes for Down syndrome will require genetic testing to reach the necessary specificity levels.*

Response: Unnecessary clinical testing is certainly not expected in order to determine a more specific ICD-10-CM code. Code assignment should reflect the known level of clinical certainty. If the clinical information to support a more specific code is not known, a less-specific code should be assigned. This is also true for ICD-9-CM coding.

Conclusion

The report by Nachimson Advisors makes a number of assumptions that AHIMA believes cannot be substantiated without significantly more study into physician practices, their use of

information technology, their current documentation practices, the current process of coding (and the impact of CPT-4® coding requirements as well as ICD requirements), the amount of HIPAA-related transaction standards actually used in the practice, and the size and nature of the practice (general medicine, family practice, specialty practice, hospital or university related, etc.).

The report also makes assumptions that the direction and requirements for claims and other reporting, including quality measurement, patient safety, public health, and so forth, will all immediately be required on the compliance date. The report particularly assumes a massive change in healthcare claims, reporting, and reimbursement all likewise occurring on day one of the use of ICD-10-CM (the compliance date). There is nothing in the proposed rule or any comments by HHS, CMS, or the major healthcare groups that substantiate these assumptions. Could, over time, all or some of the requirements changes noted in the report occur? Yes, but they will occur as part of an evolution in healthcare reform, pay-for-performance initiatives, EHR adoption, and when there is enough data to warrant taking next steps in such an evolution. They will not occur at the time of code compliance for the ICD-10-CM codes will be needed for analysis to even suggest a future change.

It would require a crystal ball to determine, at this time, what will occur first, when, and at what costs. However, we do know that any conversion cost associated with changing field size and characters to adopt ICD-10-CM will only increase the longer we wait, just as costs have increased during the various delays over the last 10 years. The sooner conversion can be made to ICD-10-CM, the smaller the changes to functional software will have to be, and the fewer conversions or translations to data warehouse information (which does not exist in most physician practices today).

While AHIMA questions the assumptions in the report, we must also point out that some of the changes envisioned, while not necessarily happening during the scope of the implementation period, are potentially on the horizon. As the report suggests, physician practices (and all providers) would do well to begin looking at their use of ICD-9-CM now and determine the processes and uses impacted by the change to ICD-10-CM. AHIMA believes there is room for improvement in most users' processes and this is a good time to consider changes necessitated by this transition. AHIMA has committed to providing the healthcare industry with whatever assistance we can to ensure a complete, organized, efficient, and effective conversion and implementation. But the time to start is now. No matter what the final rule requires as to a timeline, the standards are ready and accessible, and the sooner the industry begins to plan and implement the necessary changes, the better it can take advantage of the improved information that will be available.

The change to ICD-10-CM is not intended to burden the healthcare system. The change to ICD-10-CM is intended to improve the health information we have so as to benefit the health of individuals as well as the overall population. While some see the ICD-10-CM codes as an extension of the claims process, health information management professionals and many others

in the healthcare industry see this code system as providing much-needed health information, not only to improve our reimbursement systems and lower our administrative costs, but also to improve healthcare quality, research, patient safety, population health, and decision making. Rather than further delaying the move to a 21st century classification system, AHIMA urges the industry to move forward to a future in which healthcare costs are reduced and more and better information about healthcare provided, care needed, and new diseases and technology is forthcoming.

AHIMA is the premier association of health information management (HIM) professionals. AHIMA's 52,000 members are dedicated to the effective management of personal health information needed to deliver quality healthcare to the public. Founded in 1928 to improve the quality of medical records, AHIMA is committed to advancing the HIM profession in an increasingly electronic and global environment through leadership in advocacy, education, certification, and lifelong learning. To learn more about the association, go to www.ahima.org.

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