



**American Hospital
Association**

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October 21, 2008

Michael O. Leavitt
Secretary
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-0013-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: CMS-0013-P, HIPAA Administrative Simplification: Modification to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS; Proposed Rule (Vol. 73, No. 164), August 22, 2008.

Dear Secretary Leavitt:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 38,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Department of Health and Human Services' (HHS) proposal to upgrade the nation's coding system to ICD-10-CM and ICD-10-PCS. The AHA has long advocated for adoption of a more robust coding system and applauds HHS' move to improve our nation's diagnostic and procedure data. We urge you to ensure the final adoption of ICD-10-CM and ICD-10-PCS.

The International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) has been in use for almost 30 years. Over the last decade, it became apparent to hospitals that ICD-9-CM was outdated and in need of replacement. Health care delivery has shifted from the inpatient acute care setting to outpatient, home care, long-term care and other settings, and the ability to incorporate new codes or expand enumeration to accommodate change has been limited by the physical numbering constraints of the ICD-9-CM system. ICD-9-CM diagnostic codes are often outdated and in many instances insufficient to provide detail for non-acute conditions. Some categories provide vague and imprecise diagnosis codes. The problems are more severe for coding procedures and new devices.

The aging ICD-9-CM code set has mounting space limitations and workarounds that violate the structural hierarchy needed to handle new diagnoses and procedures. The ICD-9-CM code set was never designed to provide the increased level of detail required to support emerging needs such as quality reporting and development of value-based purchasing programs. Other



challenges include its inability to easily provide the detail for mortality and bio-surveillance reporting. Accurate coding that clearly describes diagnoses and procedures is critical to truly improve health care quality and simultaneously contain costs by enabling the study of specific conditions driving increased costs and possible options for treating them.

ICD-10-CM/PCS allows for the more detailed code assignments to capture this crucial information; equally important, it greatly reduces the administrative burden for hospitals. For example, more detailed codes would:

- Reduce the need for submission of additional documentation to support claims;
- Allow the capture of accurate data on new ways of describing diseases due to advances in medical knowledge;
- Provide data to support performance measurement, outcomes analysis, cost analysis and monitoring of resource utilization; and
- Increase the sensitivity of the classification when making refinements in applications, such as grouping methods.

Improved coding also would facilitate the adoption of health information technology.

Transitioning from ICD-9-CM to ICD-10-CM/PCS will require careful planning and coordination of resources to ensure successful implementation. A large number of provider and health plan databases and applications will be affected – virtually every application where diagnosis or procedure codes are captured, stored, analyzed or reported – and health information coding professionals and other hospital personnel will need to be retrained. However, this change is useful and long overdue.

As a result, we support an implementation date of October 1, 2012 to allow hospitals to plan and budget for these significant changes. In addition, the AHA advocates for a single compliance date for ICD-10-CM and ICD-10-PCS; that date should fall on October 1 to coincide with the federal fiscal year and traditional Medicare inpatient prospective payment system changes. We urge HHS to speed the release of a final rule to allow all stakeholders sufficient time to prepare for this transition.

The AHA is pleased to support HHS' proposal to transition from ICD-9-CM to ICD-10-CM and ICD-10-PCS. Our specific comments on the proposed rule follow.

SPECIFIC COMMENTS

ADOPTION AND MAINTENANCE OF ICD-10-CM/PCS

Adoption for Non-HIPAA Covered Entities

HHS proposes to adopt the ICD-10-CM/PCS code sets to replace the ICD-9-CM Volumes 1 and 2 code sets for reporting diagnoses and Volume 3 code set for reporting procedures when conducting standard transactions. Entities covered by the *Health Insurance Portability and Accountability Act* (HIPAA) would be required to use these codes when coding diagnoses and hospital inpatient procedures in all HIPAA transactions.

We agree with HHS' proposal to adopt ICD-10-CM as a replacement to ICD-9-CM diagnosis codes and ICD-10-PCS as a replacement to ICD-9-CM procedure codes for all HIPAA electronic transactions. We urge the Centers for Medicare & Medicaid Services (CMS) to adopt the same replacement codes for non-HIPAA transactions where ICD-9-CM codes are currently required, including the OASIS data set for the home health plan of care, the inpatient rehabilitation patient assessment instrument (IRF-PAI) for inpatient rehabilitation facilities, and the post-acute care payment reform demonstration project plan.

Coordination and Maintenance Process

The AHA supports a well-defined implementation and maintenance process that is broad-based and takes into consideration the needs of all users. It also should be predictable and take into account users' capability to adapt to coding changes when they occur. The process should establish regularly scheduled meetings to review coding changes and a date for using approved codes.

The AHA supports HHS' proposal to establish an ICD-10-CM/PCS Coordination and Maintenance Committee that would follow the same procedures used by the ICD-9-CM Coordination and Maintenance Committee to consider new codes and revisions to existing codes. The current process is well positioned to reach the broadest audience possible.

The AHA is uniquely positioned and ready to take a leadership role in the training of our members on the implementation of ICD-10-CM/PCS. Our members look to us for guidance and support in coding training and education, and we have a long-standing memorandum of understanding with HHS with regard to training assistance. Today, the AHA's *Coding Clinic for ICD-9-CM* and Editorial Advisory Board are nationally recognized resources for coding advice. As such, our established process reduces confusion and provides clarity and consistency around the interpretation of coding rules. We intend to continue to fulfill this need with regard to ICD-10-CM/PCS training.

Guideline Development

Stakeholders need clear, unambiguous instructions and consistent official coding and reporting guidelines. These should be readily available and recognized, as well as accepted by all payers – preferably as part of the HIPAA standard code set, just like the current *ICD-9-CM Official Guidelines for Coding and Reporting*.

The AHA supports the continuation of the role of the Cooperating Parties – the AHA, CMS, the American Health Information Management Association (AHIMA) and the National Center for Health Statistics (NCHS) – in the development of guidelines and clarification for the application of ICD-10-CM/PCS, as is currently done for ICD-9-CM.

PROPOSED ICD-10-CM/PCS COMPLIANCE DATE AND ROLL-OUT PLAN

Compliance Date

The successful implementation of ICD-10-CM/PCS requires significant planning, education and systems modifications. While the adoption of ICD-10-CM/PCS is welcome and long overdue, implementing the new system must be carefully orchestrated to minimize the administrative burden on providers.

The AHA urges HHS to quickly issue a final rule for ICD-10-CM/PCS adoption and implementation; the sooner the final rule is released, the more time available to prepare for the transition to ICD-10-CM/PCS.

We support a single compliance date for ICD-10-CM and ICD-10-PCS, which should fall on October 1 to coincide with the federal fiscal year and traditional inpatient prospective payment system grouper changes. Historically, all previous versions of the ICD coding systems have been implemented on a single date. If both ICD-9-CM and ICD-10-CM/PCS codes were allowed to be reported for the same date of service, an increase in coding errors, transition costs and administrative burden would occur. The AHA recommends that the selected compliance date should be enforced for all HIPAA-covered entities. It would be costly for hospitals to have dual reporting of ICD-9-CM and ICD-10-CM/PCS because a health plan, Medicare contractor or a Medicaid program has not converted to ICD-10-CM/PCS.

The AHA recommends that the compliance date should be set for a minimum of three years after publication of a final rule, but no earlier than October 1, 2012. The international implementation of ICD-10 diagnosis coding suggests that it takes a minimum of two years to implement the system. However, U.S. providers face a higher level of automation and a greater dependency upon the use of clinical coding than the rest of the world; thus, more time may be needed.

In addition, there should be a minimum of 18 months between the successful implementation of the Version 5010 HIPAA electronic transaction standards and ICD-10-CM/PCS implementation. However, preparations for both implementations can and should occur concurrently. An

additional year would ensure thorough testing of Version 5010 and allow for the development and installation of hospital-specific edits and modifications.

While many of the changes for Version 5010 of the HIPAA electronic transaction standards will make systems ready for ICD-10-CM/PCS, this would only take care of the billing systems. Other clinical, financial and quality data collection and reporting systems also will need to be converted.

This large and expensive proposal will require at least two solid hospital budget cycles in order to properly plan for and allocate resources. While hospital health information management professionals have been well aware of the impending transition to ICD-10-CM/PCS, few hospitals have developed the multidisciplinary teams necessary for a successful transition facility-wide. In addition, many hospitals depend on their health information system vendors to make system changes. However, many vendors and other stakeholders have indicated that they will not begin work on the ICD-10-CM/PCS transition until the final rule is published.

Further, the AHA makes the following additional recommendations with respect to the timeline for implementation:

- The timeline presented in the proposed rule takes into account only existing initiatives with the presumption that no new initiatives will be adopted between now and ICD-10-CM/PCS implementation. The AHA urges HHS and its agencies to adopt a moratorium on new mandates and initiatives in order to allow the health care field time to fully concentrate on ICD-10-CM/PCS implementation.
- The AHA recommends that HHS delay issuing a final rule for the HIPAA claims attachment transaction until after the compliance date for ICD-10-CM/PCS and re-evaluate the need for the standards proposed in the claims attachment proposed rule. The greater specificity afforded by the ICD-10-CM/PCS codes may mitigate the need to adopt the claims attachment transaction rule, or at the very least, parts of the rule.
- No modifications to ICD-9-CM, ICD-10-CM or ICD-10-PCS should be made in the 12 months prior to implementation to prevent confusion and additional workload. For example, if the ICD-10-CM/PCS implementation date is October 1, 2012, no modifications to ICD-9-CM, ICD-10-CM or ICD-10-PCS should be made on or after October 1, 2011.
- The AHA recommends that HHS specifically address accountability with compliance by state Medicaid programs in the final rule. Historically, many Medicaid programs have been late implementing ICD-9-CM and diagnosis-related group version changes, causing technical and financial problems for hospitals.
- The AHA recommends that health plans be ready at least 90 days before compliance with ICD-10-CM/PCS to allow for testing with providers.

Field Testing

The testing already conducted in the U.S., as outlined in the proposed rule, as well as the extensive real-life application of ICD-10 codes in other countries, is sufficiently adequate to support implementation efforts for ICD-10-CM/PCS.

AHA members, as well as the AHA Central Office on ICD-9-CM, participated in testing of ICD-10-CM/PCS. This field testing was led by the AHA and AHIMA. We feel that the testing of 6,000 medical records was thorough and representative of the types of medical records that would be coded under ICD-10-CM/PCS. In fact, as part of informal testing of ICD-10-PCS, the AHA submitted two years' worth of surgical questions referred to the AHA Central Office on ICD-9-CM for coding advice. These questions required further referral to the *Coding Clinic for ICD-9-CM* Editorial Advisory Board because distinct or clear ICD-9-CM procedure codes could not be found. Whereas before the Editorial Advisory Board had been required to spend significant amounts of time deliberating the correct ICD-9-CM selection, the field testing found coders could easily and accurately assign an ICD-10-PCS code.

Dual Coding

While some organizations may suggest the need for dual-coding (using both ICD-9-CM and ICD-10-CM/PCS concurrently), we strongly oppose this type of transition. Dual coding is unnecessary, costly and unduly burdensome to hospitals. Similar suggestions have been made during previous National Committee on Vital Health Statistics (NCVHS) hearings and the suggestion of more extensive field testing and pilot testing has been categorically rejected in the strongest possible terms by both providers and system vendors. Such a requirement would require hospitals and vendors to incur the expense of training coding staff, as well as the cost of making expensive system changes, without realizing the benefits of a more granular and modern coding system. More than 75 percent of the testing participants felt that ICD-10-CM was an improvement that did not require significantly more time for its application.

Additional Transition Recommendations

The AHA recommends the following with respect to ICD-10-CM/PCS tools and other resources during the transition period:

- Any changes to the ICD-10-CM/PCS coding system after publication of the final rule should be specifically identified in a separate addendum, similar to the addendum currently published for the ICD-9-CM annual changes. We expect information system vendors, code book publishers, health care providers and other developers of educational materials to start the conversion process to ICD-10-CM/PCS as soon as a final rule is published. Such an addendum would make it easier to identify where changes have occurred and address those individually.
- HHS should produce an ICD-10-CM/PCS CD-ROM similar to the one currently available for the official version of the ICD-9-CM. This tool should be available at a nominal cost to providers.

- The crosswalks mapping ICD-9-CM diagnosis codes to ICD-10-CM and ICD-9-CM procedure codes to ICD-10-PCS should continue to be updated for a limited time after implementation of ICD-10-CM/PCS. We recommend that HHS meet with stakeholders to determine the optimum length of time these data maps should be updated and maintained.

With respect to CMS' transition to ICD-10-CM/PCS, the AHA recommends the following:

- To ensure CMS' contractors are ready, the agency should publicly report on a periodic basis their progress in implementing the ICD-10-CM/PCS changes.
- CMS should consider contingency plans for interim payments to hospitals once ICD-10-CM/PCS is implemented in the event that there are claims processing disruptions.
- CMS should gather information related to how core measures and quality indicators could be affected and implement appropriate changes to move to ICD-10-CM/PCS.
- HHS should comment on how the prospective payment programs will be affected, or CMS should provide such information to the health care field. Such information should not be limited to the inpatient prospective payment system but also address other reimbursement programs such as critical access hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities and long-term care hospitals. The AHA expects that, overall, the use of ICD-10-CM/PCS will not result in lower/higher reimbursement as compared to levels they would receive by using ICD-9-CM.

Detailed information on how Medicare's reimbursement programs will be affected should be made available at least one year prior to ICD-10-CM/PCS implementation in order for providers to understand the impact of those changes. Providers need this information early in order to allow for hands-on training, financial analysis and financial modeling.

- CMS should direct its contractors to be ready at least 90 days prior to ICD-10-CM/PCS implementation for all policies and edits related to systems referencing diagnosis and procedure codes. Examples of such policies and edits include local coverage determination policies, national coverage determination policies, grouper applications and the Medicare Code Editor. Ideally, edits should be revised and tested with the assistance of an expert provider panel to assist with validation.

IMPACT ANALYSIS OF ICD-10 ADOPTION

Implementing ICD-10-CM/PCS will be a complex and costly process. However, no viable alternatives have been identified. For America's hospitals, migrating to a newer version of clinical code sets, capable of accurately reporting better information on diseases and procedures, is essential. Such a decision should not be based on financial considerations alone, but take into

account the shortcomings of ICD-9-CM and the consequences of maintaining a limited clinical code set incapable of recognizing advances in medical knowledge and technology.

Estimated Costs – Training

The training costs outlined for coding professionals in the proposed rule appear reasonable. The AHA recommends that intensive coder training should not occur more than six months prior to implementation of the ICD-10-CM/PCS code set. Coding professionals have indicated that this is the optimal time frame in order to retain and apply what they have learned about these codes.

The projected training time (five days) for coding professionals in ICD-10-CM/PCS also seems reasonable. For coders who only need ICD-10-CM training, one to two days of training would be adequate. ICD-10-CM retains many similarities to ICD-9-CM and experienced ICD-9-CM coders should find it easy to learn. Participants in the ICD-10-CM field-testing project conducted by the AHA and AHIMA received only two hours of non-interactive Web-based training. Aside from the ICD-10-CM guidelines, no other tools or coding resources were available to them. Yet, the coding accuracy of participants was surprisingly high at 79 percent.

While ICD-10-PCS is an entirely new classification system bearing little resemblance to ICD-9-CM Volume 3 classification or format conventions, we estimate that the training of coding professionals should not require more than three days. ICD-10-PCS is a logical system with all codes in ICD-10-PCS having a unique definition and all terminology precisely defined and used consistently across all codes. Participants in the informal test conducted with the assistance of the AHA and AHIMA in 1996 received only two hours of face-to-face training. However, they were able to successfully return to their facilities and code surgical reports without significant problems.

HHS may have overstated the costs of training and productivity losses for hospital coders. Hospital coders, as a rule, receive training on a regular basis. They do so to sharpen their coding skills, keep up with code changes and meet requirements of corporate compliance programs, as well as for continuing education to maintain their professional credentials. This includes 10 to 30 hours per year on coding alone. In fact, many large health systems have staff at the corporate level to provide system-wide coding training to ensure the accuracy and integrity of their coding process. Following this model, it may be unnecessary to incur a great deal of additional spending to train America's coders. Train-the-trainer programs could be effectively utilized to train coding leaders, who would then disseminate the information to their colleagues at the hospital. **The cost of ICD-10-CM/PCS training for coding professionals would, in many ways, replace costs already incurred by hospitals to keep up with ICD-9-CM.**

However, some basic coding knowledge also will need to be provided to other users who provide clerical support in hospitals, such as registration clerks and billers. Other professionals in need of limited training include individuals involved in administering Advance Beneficiary Notices at the point of care, laboratory professionals, rehabilitation nurses and others who work in settings where there may be limited ICD-9-CM coding.

We agree that most physicians would not require or desire ICD-10-CM training since many physician practices rely on billers or other professional coding staff and/or the use of “superbills” or other tools providing the most frequently used codes for the individual physician’s practice. These encounter forms, or superbills, would need to be updated to ICD-10-CM. However, physicians will need some “awareness training” along the lines of the training provided through existing physician continuing education mechanisms and hospital-sponsored in-services. This is similar to the type of training physicians received in recent years as hospitals adapted to Medicare-severity diagnosis-related groups and present-on-admission reporting.

Estimated Costs – Productivity Losses

The AHA agrees that, while some short-term productivity losses (up to six months) are to be expected while coding professionals and practitioners become familiar with the new codes, we do not expect a permanent decline in productivity. Once coding professionals become familiar with the new codes, the more specific code descriptions and the consistent terminology in the new codes should make it easier to select the appropriate codes. This is supported by the feedback from participants in the field testing.

We anticipate initial short-term productivity losses to be more significant in the hospital inpatient setting versus other settings since the coding professionals in this setting will be adapting to two coding systems: ICD-10-CM and ICD-10-PCS. However, because of the precisely defined terminology of ICD-10-PCS, we do not anticipate the short-term productivity loss to be insurmountable.

With regards to the anticipated productivity losses in physician offices, if an office uses the same coding process currently in place in many practices, i.e., the superbill, there should not be significant productivity loss once new superbills have been created.

Estimated Costs – Systems Issues

Changes to the coding system will require extensive and costly modifications to information systems. Hospitals use a combination of purchased software and applications developed in-house. The software applications that will require modification encompass functions such as code assignment, medical records abstraction, aggregate data reporting, utilization management, clinical systems, billing, claims submission, grouper software, advanced beneficiary notice systems, medical review systems, quality reporting systems and other financial functions. In essence, every electronic transaction requiring an ICD-9-CM diagnosis code would need to be changed. These changes include software interfaces, field-length formats on screens, report formats and layouts, table structures holding codes, expansion of flat files and coding edit logic changes. Hospitals will bear the financial burden associated with software changes as well as possible hardware upgrades. While in the end the migration will benefit the nation’s health care system, the hurdle for hospitals is the initial investment needed to prepare for these changes.

During the transition period, information systems will have to support both ICD-9-CM and ICD-10-CM coding systems, requiring additional data storage space. Small and rural health care providers in particular, many of whom are facing serious financial challenges and have less

sophisticated information systems, are further handicapped in their ability to accommodate such changes and may require additional resources and support to help them acquire information and coding system support programs.

The AHA urges CMS and Congress to consider the cost of implementing these new regulations when determining Medicare prospective payment rate updates, particularly since these regulations are not factored into the current prospective payment rates.

On the other hand, physicians will probably not need to purchase expensive practice management programs or code selection software in order to assign ICD-10-CM codes. As stated earlier, the majority of the code assignments in physician practices rely on a superbill. Only in limited circumstances when the superbill does not contain the necessary information, are office managers or coding professionals required to search for other ICD-9-CM codes. We anticipate that the process will remain the same since it is entirely possible to add ICD-10-CM codes to current superbills and still keep them to a short or manageable format. Participants in the ICD-10-CM field testing were able to correctly select codes using a paper version without the formatting devices commonly found in today's ICD-9-CM code books. In addition, AHA staff have been able to develop training materials for ICD-10-CM using only the free PDF file available from NCHS.

ANALYSIS OF ALTERNATIVES TO ICD-10

CMS considered and rejected a number of options in deciding to propose the adoption of ICD-10-CM/PCS. The AHA generally concurs with CMS' assessment.

- **Unassigned Codes.** CMS considered extending the life of ICD-9-CM by assigning codes to new diagnoses and procedures without regard to the hierarchy of the code set. ICD-9-CM's hierarchy groups procedures by body systems and then groups similar procedures that apply to a specific body system into chapters. CMS already departed from the current organizational structure of ICD-9-CM procedures when it created a variety of procedure codes in two previously unused chapters. However, the AHA does not believe this is a long-term solution to the code shortage.
- **Systematized Nomenclature of Medicine Clinical Terms (SNOMED-CT®).** SNOMED-CT® is an input system that is primarily designed for the documentation of clinical care. Using SNOMED-CT® mapped to ICD-10-CM and ICD-10-PCS permits the use of a clinical terminology as the basis for electronic health records.

CMS rejected SNOMED-CT® as an alternative for ICD-10-CM/PCS because the code sets are designed for distinctly different purposes. CMS did not believe that SNOMED-CT® qualifies under section 1172(c)(1) of Title XI of the Social Security Act, Part C, Administration Simplification as a standard for reporting medical diagnoses and hospital inpatient procedures for purposes of administrative transactions. The AHA agrees with CMS' assessment.

- **Current Procedural Terminology, 4th Edition (CPT-4).** CPT-4 was developed and is maintained by the American Medical Association to capture physician services. CPT-4 also is used to capture services performed in outpatient and ambulatory care settings. After extensive hearings and discussions, the NCVHS in 1990 issued a report that described structural problems and serious flaws with both CPT-4 and ICD-9-CM procedure codes for the inpatient setting. In 1993, an NCVHS subcommittee determined that neither system could capture services in all health care settings. Despite numerous hearings, NCVHS has not endorsed the use of CPT-4 for hospital inpatient procedure coding.
- **ICD-11.** Another option considered was to skip adoption of ICD-10-CM/PCS and wait until ICD-11 is ready for implementation. Preliminary work on the development of ICD-11 has been carried out by the World Health Organization. However, this work is at the early stages and no firm time frames for the completion of developmental work or testing have been identified. Work has not yet begun on developing the companion procedure codes needed to implement ICD-11 in the U.S. This means that the earliest projected date for implementation would be 2020, assuming that no clinical modification would be needed for the ICD-11 and that the companion procedure code set could be completed in time. The U.S. has always used a clinical modification of the ICD coding system to meet the specific requirements needed for administrative and reimbursement purposes. We have no reason to believe that ICD-11 would be different. The AHA does not believe that waiting for ICD-11 is realistic given that the ICD-9-CM system is already obsolete.

CONCLUSION

The AHA appreciates the opportunity to comment on HHS' proposal to adopt the ICD-10-CM/PCS coding system. This change is welcome and long overdue since ICD-9-CM is no longer able to meet the pressing requirements for increased granularity and specificity in a coding system. The ICD-10 code sets provide a standard coding convention that is flexible, incorporates unique codes for all substantially different procedures or health conditions, and allows for new procedures and diagnoses to be easily incorporated as new codes for both existing and future clinical protocols.

If you have any question about our comments, feel free to contact me or Nelly Leon-Chisen, RHIA, director of coding and classification, at (312) 422-3396 or nleon@aha.org.

Sincerely,

Rick Pollack
Executive Vice President