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On behalf of the

American Health Information Management Association

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"Examining ICD-10 Implementation"

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I am Sue Bowman, Senior Director of Coding Policy and Compliance for the American Health Information Management Association (AHIMA), and I would like to thank the Energy and Commerce Committee's Subcommittee on Health for the opportunity to testify today on the very important topic of ICD-10 implementation.

AHIMA is a non-profit professional association representing more than more than 101,000 health information professionals who work throughout the healthcare industry. AHIMA plays a leadership role in the effective management of health data and electronic health records needed to deliver quality healthcare to the public. AHIMA is committed to promoting and advocating for high-quality research, best practices, and effective standards in health information. AHIMA and its members work to assure that the health information used in care, research, and health management is valid, accurate, complete, trustworthy, and timely.

Implementation of ICD-10 is long-overdue. We need it – and we're ready!

Developed in the 1970s, the ICD-9-CM code set no longer fits with the needs of a 21st century healthcare system. Never before in US history has the same version of ICD been used for more than thirty years. ICD-9-CM is obsolete and no longer reflects current clinical knowledge, contemporary medical terminology, or the modern practice of medicine. ICD-9-CM's limited structural design lacks the flexibility to keep pace with changes in medical practice and technology. ICD-9-CM is used for many more purposes today than when it was originally developed and is no longer able to support current health information needs, much less future anticipated demands for detailed, high-quality health information. The ICD-10 code sets have continued to be updated since their original development, ensuring they reflect current medical knowledge and demonstrating that they have much more flexibility to accommodate expansion.

US healthcare data is being allowed to deteriorate while the demand continues to increase for high-quality data that can support new healthcare initiatives such as the "meaningful use" electronic health record Incentive Program, value-based purchasing, and other initiatives aimed at improving quality and patient safety and decreasing costs. Without a switch to a new code set, data on new diseases and technology, or important clinical distinctions in diagnoses and procedures, cannot be accurately captured, limiting the potential to analyze healthcare costs or outcomes, exchange meaningful data for individual and population health improvement, and move to a payment system based on quality and outcomes. ICD-10 also improves tracking and surveillance of pandemic threats such as Ebola which does not have its own ICD-9-CM diagnosis code. By allowing for greater coding accuracy and specificity, ICD-10 is key to collecting the information needed to implement healthcare delivery innovations such as patient-centered medical homes. ICD-10 will enable better patient care through better understanding of

the value of new procedures, improved disease management, and an improved ability to study

and understand patient outcomes, yielding benefits to patients far beyond cost savings.

Better data resulting from the use of ICD-10 is expected to lead to:

- Improvements in patient outcomes and patient safety through better data for analysis and research;

- Improved ability to measure outcomes, efficacy, and costs of treatment options, including new medical technology;

- Improved ability to manage chronic diseases by better capturing patient populations;

- More accurate reflection of patients' clinical complexity and severity of illness;

- Improved ability to identify high-risk patients who require more intensive resources;

- Improved ability to manage population health;

- Improved information sharing, which can enhance treatment accuracy and improve care coordination;

- Expanded ability to educate consumers on costs and outcomes of treatment options;

- Enhanced public health surveillance and improvement strategies;

- Improved ability to assess effectiveness and safety of new medical technology;

- Improved administrative efficiencies and lowered costs (e.g., fewer rejected and improper reimbursement claims, decreased demand for submission of medical record documentation);

- Justification of medical necessity;

- More accurate and fair reimbursement;

- More accurate representation of provider performance;

- Increased patient engagement (as a result of access to better data);

- Validation for reported evaluation and management codes; and

- Less misinterpretation by auditors, attorneys, other third parties.

Twenty-five years ago, the National Committee on Vital and Health Statistics (NCVHS) expressed concern that the ICD classification might be stressed to a point where the quality of the system would soon be compromised. More than ten years ago, the NCVHS sent a letter to the Secretary of Health and Human Services (HHS) recommending the ICD-10 code sets be adopted as replacements for the ICD-9-CM code set. Six years have now passed since the final rule adopting the ICD-10 code sets was published.

There is a cost and danger to using the outdated ICD-9-CM code set, and its continued use will increasingly have an adverse impact on the value of healthcare data. Significant costs are being incurred by the delay in replacing ICD-9-CM, including costs associated with:

- Inaccurate decisions or conclusions based on faulty or imprecise data;

- Administrative inefficiencies due to reliance on manual processes;

- Declines in coding productivity and accuracy (due to code ambiguity and outdated terminology); and

- Inability to fully realize the advantages offered by computer-assisted coding technology because ambiguity and lack of precision limit the effective use of this technology.

The decision to mandate ICD–10 was based on years of industry discussions, consensus building, and government rulemaking. Before publishing the proposed rule for the adoption of ICD–10–CM and ICD–10–PCS, the HHS Secretary considered NCVHS recommendations as well as input from federal and state agencies, private and professional organizations, and industry stakeholders, including organizations representing providers, health plans, clearinghouses, and vendors. Between 1997-2003, the NCVHS conducted eight days of hearings

with providers, health plans, clearinghouses, vendors, and interested stakeholders on the adoption of ICD–10–CM and ICD–10–PCS as a replacement for ICD-9-CM.

Several unfounded myths have persistently come up as part of the ICD-10 debate over the years. One of these oft-cited myths is that the increased number of codes in ICD-10 adds unduly to the complexity of implementation. Just as the size of a dictionary or phone book does not make it more difficult to look up a word or phone number, an increased number of codes does not make it harder to find the right code. In fact, the correct code is easier to find in a more comprehensive and detailed code set—just as it is easier to find a word in a comprehensive dictionary. Increased specificity, clinical accuracy, and a logical structure facilitate—rather than complicate—the use of a code set. Also, nearly half (46%) of the increase in the number of codes is due solely to the capture of the side of the side of the body affected by the clinical condition.

The expanded clinical detail in ICD-10 was requested by the medical community because these clinical distinctions were felt to be important to capture. The development of ICD-10 involved extensive input from the healthcare industry, particularly the physician community. A number of physician organizations, including medical specialty societies, continue to actively participate in the ongoing maintenance of ICD-10 by requesting additional clinical detail. Ninety-five percent (95%) of the requests for new ICD-10-CM codes in the past three years came from physician organizations.

No individual provider will use all of the ICD-10 codes. Each provider will use a subset of codes applicable to his clinical practice and patient population. Many of the codes have specific uses, such as for public health or worker compensation cases; these will not be normally used by

many providers. The ICD-10-CM code set is like a dictionary that has thousands of words, but individuals use some words very commonly while other words are never used. Education can be tailored to the subset of codes relevant to the provider.

While there will be a learning curve to become familiar with ICD-10-CM, ultimately it is anticipated that it will be easier to use than ICD-9-CM because of the increased specificity, greater clinical relevancy, and improved logical structure. The improved structure and specificity of the ICD-10 code set will lead to the development of increasingly sophisticated electronic tools to aid the coding process, resulting in improved coding productivity and fewer coding errors. Also, although there are many benefits from the better data produced by the specificity in ICD-10, "unspecified" codes are still available for use when sufficient clinical information is not known or available to report.

The specificity contained in ICD-10 external cause codes has been raised as another concern and as an example of the undue complexity of the ICD-10 code set. External cause codes are not unique to ICD-10. They exist in ICD-9-CM as well. Population-based injury data assist public health authorities in identifying and tracking patterns and trends in the external causes of fatal and nonfatal injuries and in designing and implementing effective injury prevention strategies. However, many providers are not currently required to report external cause codes, and they will not necessarily be required to report them after ICD-10 is implemented, either. There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of external cause codes, in either ICD-10 or ICD-9-CM, is not required.

Even for providers that do report external cause codes, just as with other ICD-10 codes, they will only report those codes that are applicable. Many external cause codes are for use in very specific circumstances. For example, most providers will never see a patient who has been sucked into a jet engine. But this code provides valuable information in a military setting. Most providers have probably had no occasion to assign the ICD-9-CM code for an accident involving injury to the occupant of a spacecraft, but the fact that such a code exists has not made ICD-9-CM more difficult to use.

Another persistent common myth is that there are viable "alternatives" to implementing ICD-10. There are no viable alternatives to implementing ICD-10. Waiting for ICD-11 or using SNOMED-CT in place of ICD has been suggested as an alternative to adoption of ICD-10. Based on the current timeline for completion and release of ICD-11, and the process for adopting and implementing a new code set standard in the US, it would be at least ten years and could be as long as twenty-five years before ICD-11 could be implemented in the US. And that presumes the current World Health Organization ICD-11 timeline does not change. The US cannot wait that long to replace the ICD-9-CM code set. Waiting that long to replace the ICD-9-CM code set would seriously jeopardize the country's ability to improve quality of care and control healthcare costs. There will always be a new version under development down the road, but in the meantime, the US can reap the many benefits from the version available for implementation today, which is a vast improvement over the version of ICD currently in use. In a 2013 report on the feasibility of skipping ICD-10 and going right to ICD-11, the American Medical Association

Board of Trustees recommended against skipping ICD-10 and moving directly to ICD-11, noting that this approach is fraught with its own pitfalls.[1]

Replacing ICD with SNOMED-CT has also been suggested. However, ICD and SNOMED-CT are complementary, not competing, systems. ICD is a classification system and SNOMED-CT is a clinical terminology. Terminologies and classifications are designed for distinctly different purposes and satisfy diverse user requirements. A clinical terminology such as SNOMED CT is an "input" system designed for the primary documentation of clinical care. Classification systems are "output" rather than "input" systems and are not designed for the primary documentation of clinical care. Classification systems group together similar diseases and procedures and organize related entities for easy retrieval. The standard vocabulary afforded by SNOMED CT supports meaningful information exchange to meet clinical requirements. ICD-10, with its classification structure and conventions and reporting rules, is useful for classifying healthcare data for administrative purposes, including reimbursement claims, health statistics, and other uses where data aggregation is advantageous.

Together terminologies and classifications provide the common medical language necessary for interoperability and the effective sharing of clinical data. The ideal situation is to link clinical SNOMED-CT concepts to ICD-10 codes for data reporting purposes where aggregation is preferred. Linked together, ICD-10 and SNOMED CT support better data collection, more efficient reporting, data interoperability, and reliable information exchange in health information systems. ICD-10 and SNOMED CT can both contribute to the improvement of the quality and

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[1] American Medical Association. "Evaluation of ICD-11 as a New Diagnostic Coding System." Report of the Board of Trustees. 2013. http://www.ama-assn.org/assets/meeting/2013a/a13-bot-25.pdf.

safety of healthcare and provide effective access to information required for decision support and consistent reporting and analysis.

Many small providers have been concerned about anticipated high costs and complexity of the ICD-10 transition. However, recent survey data involving actual physician practice implementation costs has shown the cost and burden to be much less than had previously been suggested.[2,3] Physician practices are not affected by the implementation of the ICD-10 procedure code set, ICD-10-PCS, as the American Medical Association's Current Procedural Terminology (CPT[®]) codes will continue to be used to report physician and outpatient services. The extent of ICD-10 training needed depends on an individual's role. While coders will require comprehensive ICD-10 coding education, most physicians will not. Physicians will primarily require education around the clinical documentation needed to support ICD-10 codes. Additional documentation requirements have often been cited as a major contributor to the cost of ICD-10 implementation. However, even without the ICD-10 transition, there is a growing demand for more complete and accurate documentation. And the impact of clinical documentation improvement efforts can be mitigated through the use of electronic documentation capture tools, such as documentation prompts in electronic health record systems. Also, many of the clinical details found in ICD-10 are typically already documented, such as laterality.

Free and low-cost ICD-10 educational and implementation resources are widely available from multiple sources, giving all stakeholders the ability to be fully ready by the October 1, 2015

[2] Kravis, Thomas, et al. "Cost of Converting Small Physician Offices to ICD-10 Much Lower than Previously Reported. *Journal of AHIMA,* November, 2014. http://journal.ahima.org/wp-content/uploads/Week-3_PDFpost.FINAL-Estimating-the-Cost-of-Conversion-to-ICD-10_-Nov-12.pdf.

[3] Blanchette, Karen, et al. "Survey of ICD-10 Implementation Costs in Small Physician Offices." *Journal of AHIMA*, February, 2015. http://journal.ahima.org/?p=11119

ICD-10 compliance date. The Centers for Medicare & Medicaid Services (CMS) have

conducted significant industry outreach and developed extensive educational materials and

implementation guidance resources targeted to multiple stakeholder groups, including those with

limited resources or that have been shown in the past to have been lagging behind in

implementation, such as physician practices and small hospitals. CMS has provided in-person

ICD-10 training for small physician practices in a number of states.

Many professional associations and organizations have also developed resources and

educational programs for stakeholders with limited resources to implement ICD-10. AHIMA is

a member of the Coalition for ICD-10, and Coalition members have been, and continue to be,

engage in significant efforts to identify and educate those in need of assistance to be ready for

the 2015 implementation, including payer-provider collaboratives, training and outreach

initiatives, and programs to help coders maintain their new ICD-10 coding skills. AHIMA has

worked with its state associations to conduct outreach on ICD-10 implementation to state and

local physician organizations and to provide ICD-10 education and implementation assistance to

physicians and physician groups.

Every day implementation of ICD-10 is delayed translates to considerable cost to the

healthcare industry. All segments of the healthcare industry have dedicated significant time and

resources in financing, training, and implementing the necessary changes to workflow and

clinical documentation. The repeated ICD-10 delays have been disruptive and costly for

healthcare delivery innovation, payment reform, public health, and healthcare spending. Each of

these delays has taken an enormous toll on the healthcare industry, including: significant

additional costs; diversion of ICD-10 budgets and personnel; lack of employment prospects for

students trained in a code set not yet in use; and many lost opportunities to use better data to

improve healthcare and reduce costs. The implementation delays required the ICD-10 conversion work already performed to be updated, retested, and reintegrated – greatly increasing the cost of conversion. The need to retrain personnel and reconfigure systems multiple times in anticipation of the implementation of ICD-10 is unnecessarily driving up the cost of healthcare.

HHS estimated that a one-year delay in the compliance date adds a range of 10 to 30 percent to the total cost that that entities had already spent or budgeted for the transition, equating to a cost to covered entities of $1.1 to $6.8 billion for each one-year delay.[4] The lost opportunity costs of failing to move to a more effective code set also continue to climb every year. The enormous investment that is being made in Accountable Care Organizations (ACOs), meaningful use of electronic health records and value-based purchasing are all predicated on having a more precise and comprehensive diagnosis and procedure coding system that is up-to-date with the rapid changes in practices and technologies utilized in today's healthcare system.

While there have been two delays since the ICD-10 final rule was published in January 2009, the compliance date had already been extended from the original date proposed in the 2008 rule. October 2011 was the compliance date proposed in the 2008 rule, and this date was changed to October 2013 in the final rule as a result of public comments submitted in response to the proposed rule. So the industry initially had more than four years after publication of the final rule to prepare for the ICD-10 transition. As a result of the two one-year delays granted by HHS in 2012 and Congress in 2014, the healthcare industry has had more than six years to prepare. This length of time is more than adequate for all segments of the healthcare industry to be ready

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[4] Department of Health and Human Services. "Administrative Simplification: Change to the Compliance Date for the International Classification of Diseases, 10th Revision (ICD–10–CM and ICD–10–PCS) Medical Data Code Sets; Final Rule." *Federal Register* 79, no. 149 (August 4, 2014). http://www.gpo.gov/fdsys/pkg/FR-2014-08-04/pdf/2014-18347.pdf.

for the transition. In reality, the healthcare industry has had even more time to prepare for ICD-10, as the 2008 proposed rule was not the first indication that ICD-10 was coming as a replacement for the ICD-9-CM code set.

In conclusion, it is time to stop delaying the transition to ICD-10 so that US can start reaping the benefits of a more modern code set that the rest of the world has enjoyed for a number of years now. The healthcare industry has had more than enough time to prepare for ICD-10. The way to ensure industry readiness for the compliance date is to send a very clear message that the date is not going to change, because as long as stakeholders anticipate another delay, some organizations will fail to take steps to prepare, even those that were on track. **We need ICD-10 – and we're ready!**

SUMMARY OF KEY POINTS

- We need ICD-10 – and we're ready.
- ICD-9-CM is obsolete and no longer reflects current clinical knowledge, contemporary medical terminology, or the modern practice of medicine.
- Without a switch to a new code set, data on new diseases and technology, or important clinical distinctions in diagnoses and procedures, cannot be accurately captured, limiting the potential to analyze healthcare costs or outcomes, exchange meaningful data for individual and population health improvement, and move to a payment system based on quality and outcomes.
- Significant costs are being incurred by the delay in replacing ICD-9-CM, both in terms of costs directly related to the multiple delays as well as lost opportunity costs associated with failure to transition to a more modern code set. Each one-year delay has added 10 to 30 percent to the total cost that that entities had already spent or budgeted for the transition, or $1.1 to $6.8 billion.
- Concerns about exorbitant implementation costs for small providers are not supported by recent survey data.
- The number of codes in ICD-10 does not make the code set more difficult to use than ICD-9-CM.
- Forty-six percent (46%) of the increase in the number of codes is due solely to the capture of the side of the side of the body affected by the clinical condition.
- The clinical detail in ICD-10-CM was requested by the medical community.
- Ninety-five percent (95%) of the requests for new ICD-10-CM codes come from physician organizations.
- There are no viable alternatives to ICD-10.
- The healthcare industry is well-prepared to meet the October 2015 compliance date, and free or low-cost education and implementation resources are widely available to assist small providers in making the transition to ICD-10.
- The way to ensure industry readiness for the compliance date is to send a very clear message that the date is not going to change, because as long as stakeholders anticipate another delay, some organizations will fail to take steps to prepare, even those that were on track.