



May 17, 2012

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Baltimore, MD 21244-8013.

Re: 45 CFR Part 162 [CMS-0040-P] RIN 0938-AQ13 Administrative Simplification:  
Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider  
Identifier Requirements; and a Change to the Compliance Date for ICD-10-CM and ICD-10-  
PCS Medical Data Code Sets

Submitted Electronically: <http://www.regulations.gov/>

Dear Secretary Sebelius and Ms. Tavenner,

On behalf of AMIA (American Medical Informatics Association), I am pleased to submit these comments in response to the above-referenced proposed rule. AMIA is the professional home for biomedical and health informatics and is dedicated to the development and application of informatics in support of patient care, public health, teaching, research, administration, and related policy. AMIA seeks to enhance health and healthcare delivery through the transformative use of information and communications technology.

AMIA's 4,000 members advance the use of health information and communications technology in clinical care and clinical research, personal health management, public and population health, and translational science with the ultimate objective of improving health. Our members work throughout the health system in various clinical care, research, academic, government, and commercial organizations.

AMIA thanks the Department of Health and Human Services (the Department) for issuing this proposed rule, which proposes to change the compliance date for the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding, including the Official ICD-10-CM Guidelines for Coding and Reporting, and the International Classification of Diseases, 10<sup>th</sup> Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding, including the Official ICD-10-PCS Guidelines for Coding and Reporting, from October 1, 2013 to October 1, 2014. Although the proposed rule also implements section 1104 of the Patient Protection and Affordable Care Act by establishing new

requirements for administrative transactions, AMIA's comments focus on the proposed delay in implementation of ICD-10.

### **Proposed One Year Delay**

AMIA accepts the Department's proposal to delay implementation of ICD-10 for an additional year, until October 2014. We understand that some stakeholders have voiced their concerns about the current implementation timeline in light of competing priorities, such as meaningful use, electronic prescribing, and clinical quality and performance measures.

However, AMIA would not support further delay of ICD-10 implementation beyond October 2014. Additionally, we believe that any proposals to 'skip' ICD-10 and await ICD-11 are ill-advised at this time. We understand that there would be significant technical difficulties in transitioning directly from ICD-9-CM to ICD-11. Further we understand that a US Clinical Modification for ICD-11 (if needed) will not be available until 2020 or 2021.

### **Address Specific Challenges and Problems during any Implementation Delay**

We believe that if DHHS delays ICD-10 implementation until October 2014 (or beyond), the delay must be utilized to address specific challenges and problems; alleviating such challenges will prove beneficial to all stakeholders. Thus, if the Department decides to delay implementation of ICD-10, we urge the Department to undertake and lead several industry-wide efforts, including the following:

- All stakeholders need to assess and prepare their organizational infrastructures for ICD-10 "readiness."
- All stakeholders need to adequately test a wide variety of health information technology (health IT) legacy systems for ICD-10 "readiness."
- Health IT vendors need to adequately test new/updated health IT products and systems for ICD-10 "readiness."
- DHHS should collect and disseminate "lessons learned and best practices" regarding ICD-10 implementation from those organizations that have already engaged in ICD-10 transition projects.
- DHHS should assure that EHR certification criteria require appropriate ICD-10 functionality.
- Health IT vendors need to update and test all relevant (existing) health IT products and assure clients and potential clients that ICD-10 functions perform adequately and confirm that they meet certification criteria.
- CMS should assure that their existing information and resources regarding the General Equivalence Mappings (GEM) are up to date, sufficient, and accurate.
- DHHS should assure that adequate training and educational activities and materials are available for various stakeholders and ICD-10 users/audiences, such as practicing clinicians, administrators, coders, researchers, and payers:

- Training and educating clinicians regarding the nuances of ICD-10 and associated specific documentation and clinical data requirements
- Accurate mapping of codes to/from ICD-9-CM and ICD-10

We believe that the extra time provided by an ICD-10 implementation delay could also be used to explore implementation of SNOMED CT as the primary clinical problem list terminology. In the longer term, AMIA urges CMS to explore the feasibility of using SNOMED CT concepts to capture problem list data and/or other diagnoses, and then using mappings or other data in the EHR to algorithmically generate ICD-10 codes for billing.

We also urge CMS to update its prior cost estimates of ICD-10 implementation and provide credible estimates of the costs and benefits of conversion to and implementation of ICD-10 for all stakeholders (such as: bill-submitting entities and organizations; clinicians; payers; public health providers; policymakers; and researchers). We assume that CMS estimates considered the costs already expended (“sunk costs”) by DHHS such as its costs to develop the US Clinical Modification and for CMS and its contractors to convert/update their information systems. Lost opportunity costs (for not converting to ICD-10) should also be considered.

Although CMS published ICD-10 transition cost estimates in both the August 22, 2008, Proposed Rule and January 16, 2009, Final Rule, it is not clear to what extent either estimate accurately presented the true cost of implementing ICD-10, nor if those costs are still applicable. However, since a number of organizations have recent experiences preparing for and/or implementing ICD-10, more up to date and realistic costs and associated/anticipated benefits could be obtained by surveying a representative sampling of hospitals, physician offices, and others who have engaged in ICD-10 transition projects.

### **Concluding Comments**

As a source of informed, unbiased opinions on policy issues relating to the national health information infrastructure, uses and protection of clinical and personal health information, and public health considerations, AMIA and its members are active in developing policy proposals and commentaries to inform the federal government, regional/state governments, and provider organizations in a wide variety of matters related to health IT and its effective and safe use.

For example, in 2008 AMIA and the American Health Information Management Association (AHIMA) convened a Terminology and Classification Policy Task Force composed of clinical informaticians, researchers, nosologists, and health information managers and educators, well known in the terminology and classification fields. The Task Force issued a report entitled, “Healthcare Terminologies and Classifications: Essential Keys to Interoperability” ([http://www.amia.org/sites/amia.org/files/Classifications\\_and\\_terminology\\_Interoperability.pdf](http://www.amia.org/sites/amia.org/files/Classifications_and_terminology_Interoperability.pdf)). and formulated a vision with associated goals and recommendations that it hoped would be used

to frame a public-private dialogue about regarding the U.S. approach to healthcare terminologies and classifications against a backdrop of international approaches and achievements We urge the Department to (re) consider our findings and recommendations.

AMIA appreciates the opportunity to submit these comments. Again, we thank the Department for issuing this proposed rule which we anticipate will be revised in timely fashion. Please feel free to contact me or Meryl Bloomrosen, AMIA's Vice President for Public Policy, at any time for further discussion of the issues raised here.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin Fickenscher, MD", is centered on a light pink rectangular background.

Kevin Fickenscher, MD

President / CEO