American Health Information Management Association

Testimony for the Hearing Record

Department of Health and Human Services

Task Force on Stimulating Innovation in Medical Technologies

Hearing on New Ideas and Promotion of New Solutions to Speed the Development of Effective New Medical Technologies

Monday, November 8, 2004

Statement of Dan Rode, MBA, FHFMA

Vice President, Policy and Government Relations

Mr. Chairman, members of the Task Force, we appreciate the opportunity to provide testimony on healthcare information technology on behalf of the American Health Information Management Association (AHIMA). AHIMA submits this testimony in the belief that the Department of Health and Human Services (HHS) must address the issues of health data and information collection, analysis, and communication, in order to stimulate innovation in medical technologies. If not addressed, these items will also limit HHS's ability to determine which new technology is appropriate for its beneficiaries' use, and how HHS will pay for such technology.

The focus of our testimony, therefore, is the impact of up-to-date diagnostic and procedural information on the value of clinical data, which in turn supports medical technology. Such clinical information is normally provided in the form of coding systems. For this purpose we believe it is in HHS's interest to update the US national diagnostic and procedural code set – specifically ICD-9-CM,[1] in order to significantly improve data capture regarding outcomes, efficacy, and costs of new medical technology. We propose that the Task Force recommend to the Secretary that he promulgate a notice of proposed rule making to adopt ICD-10-CM[2] and ICD-10-PCS[3] as replacements for the ICD-9-CM diagnostic and procedural coding system in the next few months.

AHIMA

AHIMA is a professional association of more than 50,000 educated and certified health information management (HIM) professionals. For over 76 years, AHIMA professionals have been responsible for the acquiring, storing, analyzing, and transferring of patient health information for a variety of purposes, including clinical support, health research, patient safety, public health, reimbursement, and policymaking. Today, we find HIM professionals in some 40 different settings within the healthcare and government sectors and holding over 200 different job titles.

HIM professionals work in provider, health plan, government, research (private and government), and other public and private organizations, facilities, practices, and agencies. AHIMA members, serving as directors of various HIM (medical record) departments for various healthcare providers and health plans, are usually charged with providing health information and data to a variety of third parties in the healthcare services cycle, including health plans or payers; state departments of health, public health, or welfare; state, employer or similar health plan quality initiatives, and so forth. They are also involved in ensuring the completeness and integrity of the data and in ensuring the data reported receive appropriate confidentiality and privacy protection.

The Task Force should also be aware that AHIMA serves as one of the Cooperating Parties, which along with the Centers for Medicare and Medicaid Services (CMS), the American Hospital Association (AHA), and the National Center for Health Statistics (NCHS), are

---

1 *International Classification of Diseases, Ninth Revision, Clinical Modifications*
2 *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Clinical Modifications*
3 *International Classification of Diseases, Tenth Revision, Procedural Coding System*

responsible for developing guidelines and direction for the proper application of ICD-9-CM. This relationship began in the 1960s and each of the organizations has been dedicated to enhancing data integrity and consistency of coding. This is a very challenging job, and one that has become immeasurably more difficult in recent years.

Role of Code Sets in the Use of Medical Technology

Diagnostic Coding

ICD-9-CM, volumes 1 and 2 (hereafter referred to as *diagnosis codes*), represent a diagnostic coding system that is a US modification of the World Health Organization's ICD-9, which was adopted and implemented in the US in 1979. In 2000, ICD-9-CMS was adopted under the HIPAA regulations for electronic transactions and code sets as the required code set for diseases, injuries, impairments, other health problems, and causes of injury, disease, impairment, or other health problems. The Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) serves as the administrator of ICD-9-CM in the US.

Procedural Coding

ICD-9-CM, volume 3 (hereafter referred to as *procedure codes*), is a procedural coding system developed by the CMS (then the Health Care Financing Administration – HCFA) and was also adopted and implemented in 1979 to be used in conjunction with ICD-9-CM diagnosis codes. In 2000, volume 3 was adopted under the HIPAA regulations for electronic transactions and code sets as the required code set for procedures performed on hospital inpatients and reported by hospitals for the prevention, diagnosis, treatment, and management of diseases, injuries, and impairments.

Uses for Diagnostic and Procedural Coding in CMS

In addition to serving as the basis for Medicare's acute-care hospital inpatient and long-term acute care hospital prospective payment systems, ICD-9-CM coded data are used for many other purposes, including:

- Measuring the quality, safety, and efficacy of care,
- Making clinical decisions based on output from multiple systems,
- Designing payment systems and processing claims for reimbursement,
- Conducting research, epidemiological studies, and clinical trials,
- Setting health policy,
- Operational and strategic planning and designing healthcare delivery systems,
- Monitoring resource utilization,
- Improving clinical, financial, and administrative performance,
- Identifying fraudulent or abusive practices,
- Managing care and disease processes,
- Tracking public health and risks, and

- ?? Providing data to consumers regarding costs and outcomes of treatment options.

Complete, accurate, and up-to-date ICD-9-CM codes are necessary in order to capture accurate data about the outcomes, efficacy, and costs of new medical technology and to ensure fair and equitable reimbursement policies for the use of this technology. Examples of proposals for new procedure codes representing technological advances that have been presented at the ICD-9-CM Coordination and Maintenance Committee (C&MC) meetings over the last few years include:

- ?? Use of heart replacement and assist devices
- ?? Insertion of carotid stent
- ?? Implantation of cardiac support device
- ?? Insertion of rechargeable neurostimulator pulse generator
- ?? Insertion of recombinant bone morphogenetic protein
- ?? Infusion of Xigris™
- ?? Cardiac resynchronization therapy
- ?? Insertion of drug-eluting stents

Up-to-date ICD-9-CM diagnosis codes that reflect current medical knowledge are also important for accurate data capture in the use of new medical technology because they are used to:

- ?? Substantiate the medical necessity of diagnostic and therapeutic services,
- ?? Support the efficacy of the technology for various clinical conditions, and
- ?? Identify complications and adverse effects from the use of the technology.

Examples of proposals for new and revised diagnosis codes related to technological advances in diagnosis and treatment or to advances in clinical knowledge that have been presented at the C&MC meetings over the last few years include:

- ?? Complications of insulin pump
- ?? Elevated C-reactive protein
- ?? Abnormal pap test results (revisions necessitated by an updated version of the Bethesda system)
- ?? Genetic susceptibility to disease
- ?? Atherosclerosis of bypass graft of transplanted heart
- ?? Sepsis, severe sepsis, and systemic inflammatory response syndrome
- ?? Sleep disorders
- ?? Chronic kidney disease
- ?? Refractory anemia
- ?? Metabolic disorders

ICD-9-CM Is Broken, Inadequate, and Must be Replaced Soon

Implemented nearly 30 years ago (and developed even earlier), the ICD-9-CM diagnostic and procedural coding systems are outdated and obsolete and must be replaced as soon as possible. If one contemplates how medical practice has changed in the past 30 years, it is easy to

understand how grossly inadequate ICD-9-CM is. The World Health Organization (WHO), which holds the copyright on ICD-9 – the core of ICD-9-CM – no longer supports this version.

Since the ICD-9-CM diagnostic and procedural coding systems were implemented in the 1970s, many dramatic advances in medicine and medical technology have occurred that were not anticipated and have not been adequately accommodated. For example, laser and laparoscopic surgeries were not performed at the time ICD-9-CM was implemented, but, today, this technology is now commonly used for many types of procedures. These classification systems are no longer able to adequately accommodate the rapid advances in medical care, including the myriad technological developments.

The growing inadequacies of ICD-9-CM have been recognized for some time. Fourteen years ago, in 1990, the National Committee on Vital and Health Statistics (NCVHS) reported to the HHS that there were problems with the continued ability of ICD-9-CM to keep pace with medical science. The NCVHS indicated that both the ICD-9-CM diagnostic and procedural coding systems would need to be replaced. In a 1993 report, the NCVHS noted that the ICD-9-CM procedural coding system[4]:

- Has insufficient structure to capture new technology,
- Contains overlapping and duplicative codes,
- Includes inconsistent and outdated terminology,
- Lacks codes for certain types of services, and
- Lacks sufficient specificity and detail.

ICD-9-CM Cannot Accommodate Innovation in Medical Technologies

The structure of ICD-9-CM is not sufficiently flexible to continue to accommodate revisions needed to identify the use of new medical technology. The limitation of the four-digit structure of ICD-9-CM's procedural coding system allows little room to make substantive changes. Once a category is full, types of similar procedures must either be combined under one code, or a place for a new code must be found in another section. The latter approach compromises the ease with which aggregate data on related procedures can be collected, ultimately disrupts the design and structure of the coding system, and is only a short-term solution.

Although the C&MC has attempted to make code modifications to capture new technology, it has sometimes been difficult to achieve a reasonable result. Making needed changes to the ICD-9-CM coding systems have become increasingly difficult each year and involve making compromises that affect the precision of the coding and therefore impact the information that can easily be used by those collecting or receiving the data.

Regardless of the merits of a proposal for a new procedural code to represent new medical technology, if there are no available code numbers within the ICD-9-CM structure, the C&MC

[4] National Committee on Vital and Health Statistics. "*Recommendations for a Single Procedure Classification System.*" November 1993.

will soon have no choice except to classify the new technology to an existing code that encompasses other technologies. This will result in an inability to identify instances (information) when the new technology is used. Therefore, it will be impossible to compare outcomes and efficacy between older and newer technologies, identify costs associated with the new technology, or revise reimbursement policies to appropriately reflect the cost of patient care when the new technology is used. Currently, ICD-9-CM procedure codes often fail to distinguish between significantly different technologies. It is difficult to track data on new procedures when they are classified to general, nonspecific codes. Many of the terms used in the ICD-9-CM procedural coding system can have a variety of meanings and interpretations, resulting in difficulty and inconsistency in determining the most appropriate code.

The 9 C&M and CMS have also experienced significant problems caused by the Benefits Improvement and Protection Act of 2000 (BIPA). BIPA requires that new services and technologies be incorporated into the hospital inpatient prospective payment system more expeditiously. Since ICD-9-CM codes serve as the foundation for this prospective payment system, this requirement necessitates the establishment of new ICD-9-CM procedure codes to represent new services and technology. Since the ICD-9-CM procedural coding system has already proven to be increasingly inadequate in accommodating routine annual code updates, it most certainly will not be able to accommodate all the new codes needed to represent technological advances, as required under BIPA. For example, the 9 C&M has already been forced to create codes for diverse procedures, affecting different body systems, in limited unused ICD-9-CM procedure code categories because there is no room to expand the category where the procedure more appropriately belongs. This impedes the ability to accurately collect data on related procedures, and, as stated earlier, is only a short-term solution. Code number limitations also result in the 9 C&M being more selective in determining which new services and technologies will be granted unique codes than they would be if limited code number were not an issue.

ICD-10-CM and ICD-10-PCS Are Ideal Replacements for ICD-9-CM

ICD-10-CM is a US modification of the WHO's ICD-10 and was designed to replace the ICD-9-CM diagnostic coding system. ICD-10-PCS was developed under a CMS contract as a replacement for the ICD-9-CM procedural coding system. Both systems represent a significant improvement over ICD-9-CM and were specifically designed to describe today's practice of medicine and to incorporate sufficient flexibility to handle advances in healthcare well into the future.

Coded data, based on ICD-10-CM and ICD-10-PCS, would permit improved underwriting and payment methodologies; more precise research sampling, tracking, and trending of patient outcomes and costs; more reliable performance data for consumers, to name just a few benefits. In addition to reflecting current medical knowledge and practice, ICD-10-CM and ICD-10-PCS classification systems incorporate a much greater level of specificity than ICD-9-CM, allowing significantly improved data analysis necessary for research, assessment of outcomes and efficacy, and refinement of reimbursement systems. For example, there is growing interest in tying reimbursement to quality of care, but it is difficult to make great strides in that direction

without better data for assessing the quality of care. In fact, it is difficult to make any major refinements to our reimbursement systems without better data regarding patients' clinical conditions and the services provided.

A year ago, in November 2003, the NCVHS sent a letter to the Secretary recommending initiation of the rulemaking process for adoption of ICD-10-CM and ICD-10-PCS. This recommendation came after extensive hearings, discussion, and a Rand study. The NCVHS concluded that the ICD-9-CM diagnostic and procedural coding systems have structure and space limitations that increasingly constrain their ability to accommodate advances in medical knowledge and technology. The NCVHS noted that while the benefits of adopting ICD-10-CM and ICD-10-PCS are harder to quantify, they appear to outweigh the costs, as evidenced by the cost/benefit analysis conducted by the Rand Corporation.

The benefits documented in testimony before the NCVHS Subcommittee on Standards and Security and the Rand study include facilitating improvements to the quality of care and patient safety, fewer rejected claims, improved information for disease management, and more accurate reimbursement rates for emerging technologies. The NCVHS concluded that it is in the best interests of the country as a whole that ICD-10-CM and ICD-10-PCS be adopted as HIPAA standards for national implementation as replacements for current uses of ICD-9-CM volumes 1, 2, and 3.

While the NCVHS reviewed and discussed the merits of moving forward with an upgrade to ICD-10 based classification systems, members of Congress, concerned with the advancement of medical technology, also added language to the Medicare Prescription Drug, Improvement and Modernization Act (MMA), urging Secretary Thomson to move forward with the promulgation of rules for adopting and implementing ICD-10-CM and ICD-10-PCS. To date no action has been taken on either of these recommendations. Meanwhile the need for accurate, complete healthcare data related to medical technology grows.

The US is the only major country not to implement upgraded versions of ICD-10. Ninty-nine other countries large and small have implemented ICD-10. In testimony before the NCVHS, system vendors indicated that it would take at least two years (post final notice) for ICD-10-CM and ICD-10-PCS to be implemented. This means that following a usual schedule, the US would not be able to implement ICD-10-CM and PCS until October 2007, if a final rule is reached before October 1, 2005 – less than a year away!

In October, AHIMA held its 76th national convention here in Washington, DC. This meeting was also the site for the 14th Congress of the International Federation of Health Record Organizations (IFHRO). At this joint meeting, AHIMA members and guests heard about the advances other countries are experiencing with the use of ICD-10. We heard from counties that hoped the US would adopt the CM and PCS systems, so they too could then use these systems, but could not wait. We heard from counties that visited our CMS and CDC Web sites to learn, and perhaps copy, from our development of ICD-10-CM and ICD-10-PCS. And, we heard how other countries use ICD-10 systems to advance their understanding and technologies of medicine.

Our HIM professionals left this conference with the full knowledge that this country, for some reason, does not understand the value of good, precise and in-depth, health data and information. They left knowing that our country, in spite of the problems surrounding our use of ICD-9-CM, still prefers using multiple paper records, copies and similar data to gain the additional in-depth information other counties have today in electronic format thanks to use of modern classification systems. Our AHIMA members – HIM professionals, educated on the value of good health information for research, technology development, public health and so on – left this convention wondering why our government does not see this link, or this need. Today, we hope that you will, in your deliberation, take our message forward.

Conclusion

Today, we come to this Task Force hearing to ask that you add your voices to those urging the Secretary to promulgate a notice of proposed rule making to adopt ICD-10-CM and ICD-10-PCS as upgrades for the ICD-9-CM diagnostic and procedure coding system. We ask that you let the Secretary know of this impact that such coding and classification systems have on the ability of US companies and healthcare professionals to increase their innovation in research and medical technology. We ask you to look at why the CDC and CMS have worked so hard to develop these systems, only to have them ignored.

The facts are there. The need to motivate and stimulate innovation in medical technology exists more than ever. Adopting, implementing, and using 21st century classification and coding systems can only serve to meet these challenges and provide the necessary information.

Thank you for the opportunity to present our case for this cause.

For Questions and Further Information:

Dan Rode, MBA, FHFMA
Vice President, Policy and Government Relations
AHIMA
1730 M Street NW, Suite 409
Washington, DC 20036
(202) 659-9440
dan.rode@ahima.org

Sue Bowman, RHIA, CCS
Director, Classification and Coding
AHIMA
233 North Michigan Avenue, Suite 2150
Chicago, IL 60601
(312) 233-1100 ext. 1115
sue.bowman@ahima.org