



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

October 14, 2008

Mr. Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services
Dept. of Health & Human Services
Attn. CMS-0013-P
P. O. Box 8016
Baltimore, MD 21244-8016

Dear Mr. Weems,

I am writing on behalf of the American Academy of Family Physicians (AAFP), which represents over 93,000 physicians and medical students nationwide. Specifically, I am writing to offer comments on the proposed rule to adopt the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) for hospital procedure coding with a compliance deadline of October 01, 2011.

The AAFP does not support the transition to ICD-10-CM because we do not find that there is good rationale for making such a significant change. While understanding the need for adoption of ICD-10-PCS to provide a more workable code set for inpatient procedural coding, the rationale for adoption of ICD-10-CM diagnosis code set is insufficient to support the extreme overhaul of the current outpatient medical system required for the transition. We encourage CMS to consider adoption of the ICD-10-PCS only.

The purported benefits of the transition to 68,000 ICD-10-CM diagnosis codes are largely based on assumptions and not supported with any real world trial involving practicing physicians in the United States. While adaptations of ICD-10 have been adopted in other countries for diagnosis coding, the healthcare environments of these countries are not similar to the United States. Nearly every sector of the U.S. has called for reform of the healthcare system to provide universal coverage, improved quality of care, better payment for primary care, and less administrative burdens. Though efforts to change the delivery and payment for primary care are being initiated, such as the Centers for Medicare and Medicaid Services' (CMS's) patient-centered medical home demonstration project, there is no imminent relief.

Meanwhile, since the year 2000, system upgrades and the introduction of Health Insurance Portability and Accountability Act (HIPAA) transaction and code sets, physicians have faced multiple mandated and unfunded system changes; each promising a simpler or better

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healthcare system. Physicians have seen little benefit from these changes as they struggle to provide quality care to an aging and unhealthy population while keeping their practices financially viable and meeting the demands of an ever-changing bureaucracy. We fear that change fatigue and financial hardships are becoming chronic conditions common to the healthcare industry. CMS may not be able to offer a cure for these conditions, but it can avoid adding to the burden by delaying indefinitely the adoption of the ICD-10-CM diagnosis code set and instead adopting only the ICD-10-PCS.

Our recommendation that CMS not adopt ICD-10-CM is further supported with the following:

- ◆ Enhancement and adoption of electronic health records (EHR) must come first
- ◆ ICD-9-CM diagnosis codes meet the needs of patient care
- ◆ Biosurveillance and research needs can be met through the mapping of ICD-9-CM to ICD-10-CM
- ◆ Disease management programs are not dependent on diagnosis codes
- ◆ CMS's estimates of coding education needs are not accurate
- ◆ Changes required for adoption of ICD-10 are substantial
- ◆ Lack of resources to support physician adoption

Electronic Health Records (EHR)

Like the current Administration, the AAFP has encouraged the adoption of EHR. We have also encouraged adoption of patient registries and e-prescribing. Whether fully integrated systems or individual components connected by interfaces, these systems may require updates related to ICD-10-CM. The costs and disruption of a transition to ICD-10-CM coding at this time could be devastating to those practices that have already invested in these technologies and further delay adoption by others. Mandating ICD-10-CM will, in AAFP's opinion, retard the adoption of EHRs and other health-IT. Cost is one of the major barriers to EHR adoption and a required transition to ICD-10-CM will siphon financial resources away from EHR preparation, selection, and implementation.

Instead of forcing an untimely and likely chaotic change to ICD-10-CM now, CMS should work closely with the Certification Commission for Health Information Technology, the Health Information Technology Standards Panel, and the industry to encourage adoption of standard clinical terminology and clinical classifications to support ICD-10-CM in EHR prior to adoption of ICD-10-CM for claims reporting purposes. The notion of adopting ICD-10-CM for claims reporting in order to drive change in EHR systems is flawed. Substantial benefits could be realized from designing the systems to most effectively capture and classify data using standard clinical terminology and classification systems such as SNOMED-CT® and the International Classification for Primary Care (ICPC). This would allow for automated coding of clinical data which would greatly lessen the need for education and retooling of non-automated tools for ICD-10-CM coding and also reduce the risk of coding errors.

CMS notes SNOMED-CT®, a clinical terminology designed for primary documentation of clinical care, would need to be mapped to ICD-10 to be useful for healthcare transactions such as billing, and we agree. However, ICPC, a clinical classification system developed by the International Classification Committee of the World Organization of Family Doctors, has already been mapped to SNOMED_CT® and ICD-10 and adopted in primary care practices

around the world. ICPC provides a logical framework for classifying the reason for encounter, diagnosis and problems, and process of care. The system can be used in paper format but is most optimal in an electronic database and has been incorporated into EHR systems, especially in the United Kingdom. The AAFP believes that ICPC may be an important element of health information technology for primary care in the U.S. and has developed a proposal for a demonstration project to determine its potential. We would welcome the support of CMS in this effort.

CMS should focus on assisting the adoption of clinical vocabularies that support the future needs of quality reporting, pay for performance, and health & wellness. CMS should also redirect its resources from the transition to ICD-10-CM and first concentrate efforts on encouraging the establishment of technology to support the transition.

Patient Care

The “significant improvements in coding primary care encounters” indicated in the proposed rule may be useful to physicians if diagnosis codes alone become a basis for managing patient care but this is unlikely.

In fact, ICD-10-CM codes for some of the most common diagnoses seen in the family medicine practice do not provide more specificity. Reporting ICD-10-CM code E11.9, Type 2 diabetes mellitus without complication is not more specific than reporting ICD-9-CM code 250.00, Diabetes mellitus, type II, without complication, not stated as uncontrolled. The same can be said for ICD-10-CM code I10 Essential (primary) hypertension as opposed to code ICD-9-CM 401.9, Hypertension, unspecified.

Where greater specificity is offered by ICD-10-CM, it is unlikely to change the care plan agreed upon by the patient and/or family and the physician. While ICD-10-CM code H65.191, Other acute nonsuppurative otitis media, right ear, is more specific than ICD-9-CM code 381.00, Acute nonsuppurative otitis media, unspecified, the affected ear would already be noted in the clinical record and this information is unnecessary for payment purposes.

The ICD-9 diagnosis codes report the information needed by the payer to determine medical necessity and available plan benefits for the services billed. It would be uncommon for the greater detail or more clinical relevance of ICD-10 diagnosis codes to influence the payment process or level of payment. As the change to ICD-10-CM would not enhance patient care or claims payment, it would bring little benefit to practicing physicians and their patients.

Biosurveillance and Research

Because the World Health Organization uses ICD-10 for both mortality and morbidity tracking, ICD-10 is the preferred method of reporting and comparing data. However, there is a crosswalk that may be used to convert ICD-9-CM to ICD-10-CM codes including those for conditions such as anthrax, Severe Acute Respiratory Syndrome, and monkeypox. While this may not be an ideal means of capturing morbidity data, this work-around is likely sufficient and reasonable when compared to the massive undertaking that will be necessary if all covered entities and their associates must convert to ICD-10-CM. The potential disruption to care during a change to ICD-10-CM is of greater concern than the ease with which codified data may be compared.

There would likely be more advantage to researchers if resources were diverted from the ICD-10-CM transition to promotion of increased adoption of EHRs and clinical classification systems such as ICPC. This would allow for automated and less error prone data collection and cross-walking to classifications such as ICD-10.

Disease Management

As noted in the Rand study¹, care management organizations do not primarily rely upon diagnosis codes in their selection of patients for disease management services. More substantial data comes from the tests and procedures performed, comorbidities noted, and medications prescribed. In some cases, standard clinical terminology is used to identify patients who would benefit from disease management services. Reliance on ICD-10-CM is highly unlikely given that more reliable and complete information is already collected from these sources.

Coding Education

It is interesting that CMS, which holds physicians responsible for the codes submitted on their claims, assumes that only one in ten physicians will choose to undergo at least four hours of training on the ICD-10 code set. At a minimum, all physicians will need to be aware of the basic guidelines and construct of the code set. Coding in physician practices is probably best represented by data from the American Academy of Professional Coders (AAPC) which has 71,000 members. From a January 2008 AAPC survey on the work of the coder², the following results provide a glimpse of the “real world” of physician practice coding not found in the American Hospital Association/American Health Information Management Association study³ referenced in the proposed rule:

- ◆ 89.9% or 10,500 of responding coders held the Certified Professional Coders (CPC) credential that certifies their expertise in coding for the physician-based setting
- ◆ All respondents performed a mix of administrative, claims administration/coding, and clinical duties
- ◆ 23% of responding coders described their work environment as a physician practice with 1-9 physicians, 26.2% in a physician practice with 10 or more physicians, 11.8% in a billing company, and 9.8% outpatient hospital
- ◆ 51.9% of responding coders agreed or strongly agreed with the statement, “Physician(s) in my office have a solid knowledge of coding and compliance rules.”
- ◆ 63.5% of responding coders agreed or strongly agreed with the statement, “My provider does ICD-9-CM coding for his/her services.”
- ◆ 57.9% of responding coders agreed or strongly agreed with the statement, “My provider selects ICD-9-CM codes from a cheat sheet or pick list.”
- ◆ 77.1% of responding coders agreed or strongly agreed with the statement, “Providers expect the coding staff to always review and correct their coding as necessary.”

¹ “The Cost and Benefits of Moving to the ICD-10 Code Sets”,

http://www.rand.org/pubs/technical_reports/2004/RAND_TR132.pdf, accessed 09/23/09

² “Work of a Coder: Surveys Tells Us Who We Are”, <http://www.aapc.com/MemberArea/resources/work-of-a-coder.aspx>, accessed 09/18/08

³ “ICD-10-CM Field Testing Project”, http://www.ahima.org/icd10/documents/FinalStudy_000.pdf, accessed 09/18/08

As indicated by these results and others in this survey, physicians and their coders work together to accurately and efficiently code and to comply with regulatory and payer guidelines. While cheat sheets and superbills are commonly used, these are tools for the initial code selection and may not represent the final work product. Physicians and coders will need coding education and also time to conduct trials to develop and measure proficiency. This will be a large burden both in terms of time and financial considerations. CMS must not under-estimate the extent to which physicians, coders, and payers rely upon accurate diagnosis coding or the training required to choose the correct code for each service rendered in each patient encounter.

Changes Required

For family physicians, the adoption of ICD-10 will not be limited to a two hour conversion of a superbill, as suggested in the proposed rule. Members of the AAFP and subscribers to *Family Practice Management* (FPM) often use FPM's short list of 600 commonly used diagnosis codes, FPM's long list of 1500 commonly used diagnosis codes, or a searchable personal digital assistant database of diagnosis codes as tools to lead them toward the required codes for an encounter. While many physicians will use a small set of the 68,000 ICD-10 diagnosis codes, this is not true in family medicine, other primary care specialty practices, or many other specialties that deal with a broad range of complaints and conditions.

We also note that code selection and entry into a billing system or onto a paper claim is only one activity involving diagnosis codes in the physician practice. Diagnosis codes are used in determining the coverage of services subject to local coverage determinations or national coverage decisions. The codes also play a key role in prior authorizations, referrals, and quality improvement activities including the Physician Quality Reporting Initiative (PQRI).

The time needed for practices to determine each activity that is affected by the change to ICD-10-CM and develop resources and processes to facilitate the change will vary but these activities do increase the time and effort beyond the assumptions in the proposed rule and likely beyond the capacity of practices already struggling to provide quality patient care while meeting the demands of already enacted regulations and initiatives.

Lack of Resources

CMS's suggestion that the costs of this change will be minimal for physicians shows a lack of understanding of the physician practice environment. As noted recently in the Medical Group Management Association's September 9, 2008, press release⁴, the gap between practice operating expenses and revenues swelled to 6.29% for multispecialty primary care practices and is similar for family medicine single specialty practices. In the current financial environment, any increase in overhead costs has a substantial impact on the practice and in turn, the ability to provide health care services.

Physicians today are not only struggling with payment issues but also, as previously noted, with implementation of EHRs and e-prescribing, efforts to participate in quality improvement

⁴MGMA e-source: Medical Group Practice Costs Outpace Revenues <http://www.mgma.com/article.aspx?id=21926> accessed 09/16/08

activities, such as the PQRI, and maintaining compliance with myriad, ever-changing payment policies and regulations. CMS must realistically consider whether pressures to rapidly adopt the ICD-10-CM code set outweigh the importance of supporting the already fragile backbone of patient care, primary care medicine.

In conclusion, and for all the reasons stated above, CMS should not implement the ICD-10-CM code set at this time and instead develop a strategic plan to first support development of enhanced technology and then provide for a transition to ICD-10-CM that would be less disruptive and undoubtedly more beneficial to those who seek its adoption.

We appreciate the opportunity to provide comments to CMS on this important matter.

Sincerely,

A handwritten signature in black ink, appearing to read "JK MD". The signature is stylized and cursive.

Jim King, M.D.
Board Chair

JK/ch