

## NCHICA Comments on NPRM for ICD-10

The North Carolina Healthcare Information and Communications Alliance, Inc (NCHICA) is submitting the comments contained in this document on 45 CFR Parts 160 and 162 *HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS; Proposed Rule*. NCHICA is a nonprofit consortium of nearly 200 organizations dedicated to improving health and care by accelerating the adoption of information technology and enabling policies. These comments were prepared by the NCHICA HIPAA Transactions, Code Sets and Identifiers (TCI) Workgroup and approved by the NCHICA Board of Directors. The workgroup is represented by health care providers, health plans and software vendors who support North Carolina covered entities.

1. **Support of single implementation date.** We agree that there should be a single implementation date, since this is a medical code set. However, we need a later compliance date.
2. **Support of staggered compliance dates.** We also agree that the ICD-10 compliance date needs to be later than the 5010 compliance date so that the industry has a stable systems environment before taking on the huge implementation of ICD-10.
3. **Start of implementation period.** The implementation period needs to start with the effective date of the final rule, not the date the final rule is published. That effective date should be at least 2 years after the effective date for 5010. (We are not referring to the compliance date.)
  - Organizations need time to budget
  - Only high-level analysis done during NPRM comment period, not detailed systems analysis
  - Industry needs time to become educated on ICD-10
  - Time is needed to get key prerequisites in place – final coding guidelines, tested national cross-walks, groupers, maintenance procedures for ICD-10 codes and cross-walks
  - There are not enough IT/IS resources to work on 5010 and ICD-10 at the same time
4. **Longer implementation period.** More time is needed than the 18 months after the compliance date for 5010. We support reasonable industry estimates for implementation, which start at a 3-year minimum. If the implementation is shortened too much, there will be several risks.
  - Many will be forced to implement using cross-walks, which eliminates the benefits of ICD-10. In fact, the data will be worse, because a perfect cross-walk is not possible. To get the benefits of ICD-10, it must be integrated into systems, not cross-walked. A longer implementation period will give the industry time to implement properly and only use cross-walks to bridge to historical data for research and reporting.

- Many will be forced to comply using cross-walks, which if not well thought out, can result in entities not seeing the benefits of ICD-10. Covered entities need time to understand the value that ICD-10 presents to their organizations and to determine how to comply with the Regulation in a way that best allows them to realize that value.
- It will have a major impact on systems, policies, staff education, reporting and contracting, including the impact on groupers. The administrative burden of additional documentation to support more specific codes will affect patient care, while providers take additional time as they adapt to using the new code set. A longer preparation period would result in a reduced impact after compliance.
- A rushed implementation could result in additional manual audit work required to resolve problems and a higher volume of adjustments when the code sets are not used correctly.
- This project must take other competing efforts into consideration. Otherwise, it may lead to significant inefficiency and potential failure in accomplishing the goals.
- The Department mentioned that health plans and providers are accustomed to going through re-contracting processes. However, what the Department omitted is that nowhere has every health plan re-contracted with every provider at the same time. Health plans will issue fee schedules and providers will be put in the position of having to perform analyses of each of these to determine the financial impact and then attempt to negotiate the fees. The current implementation period will result in this activity occurring within a compressed time frame. A longer implementation period creates an opportunity to mitigate this problem.

5. **Support NCVHS recommendation concerning start of ICD-10 implementation.** We support the NCVHS recommendation in the letter to HHS dated September 26, 2007 for beginning work after entities have achieved Level 1 compliance for 5010 (completion of development work and ready for trading partner testing.) The industry does not have resources to develop both at the same time.

6. **Prerequisites for ICD-10 implementation.** Before work on ICD-10 can start, the industry needs final guidelines, a single authoritative cross-walk that has been thoroughly tested, and national education separate from the Medicare-specific education.

- A good cross-walk is needed to ensure integrity of research and reporting that encompasses service dates before and after the compliance date. It could also be a good tool in analysis for system changes.
- Different levels of education are needed depending on the role, such as coders, physicians, business staff, report writers, etc.
- A good cross-walk also speeds the time to compliance and reduces the costs for those organizations that choose to use a cross-walk as part of their compliance strategy.

7. **Recognition of necessity of maintaining ICD-9 for a significant period.** Submission of claims can be delayed as much as 2 years, and adjustments can go back even further.

8. **Consideration of additional impacts on providers.**

- While we support advances in infrastructure, such as the adoption of ICD-10 as a means to improve quality and safety, we recognize the pervasiveness of the use of ICD-9 within our integrated clinical and financial systems and health information exchanges.

- In support of industry goals, we are working on many initiatives, such as providing support for e-prescribing, continuity of care, registry, and quality reporting, just to name a few. While we fully support rapid advancement, we must be cognizant of constraints of vendor and provider resources in implementing all of these capabilities across initiatives.
9. **Close monitoring of progress.** Because of the effort involved and lack of experience in moving to a new code set, we recommend the final rule include a plan for monitoring progress and options in the event the entire industry is not ready by the compliance date named in the rule. One option is that CMS could maintain an updated Critical Path Method (CPM) schedule to track implementation progress with published updates every six months to advise the industry if there is any slippage on any component of the schedule that will affect the overall timeline. This might be similar to the NCHICA WEDI timeline that is published on the NCHICA web site at: <http://www.nchica.org/HIPAAResources/timeline.htm>.