

Achieving ICD-10-CM/PCS Compliance in 2015: Staying the Course for Better Healthcare—A Report from the AHIMA 2014 ICD-10/CAC Coding Summit

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Abstract

The American Health Information Management Association (AHIMA) convened its annual ICD-10-CM/PCS and Computer-Assisted Coding Summit in April 2014 in Washington, DC. This event provides a forum for thought leaders from all segments of the healthcare industry, including providers, payers, vendors, consultants and secondary data users, to engage in open discussion to better understand the perspectives of other stakeholder groups and to develop opportunities for collaboration and networking. The 2014 summit took place in the immediate aftermath of a Congressional action that delayed the implementation of the new ICD-10 code sets, which had been expected to occur in October 2014, and it served as an opportunity for industry leaders to discuss issues resulting from the delay, as well as other ICD-10 related issues. This paper presents findings and discussions from the 2014 summit and includes short-term issues related to the recent delay in implementation. It also summarizes current thinking about opportunities for leveraging ICD-10-CM/PCS data and challenges in achieving timely ICD-10 readiness. Finally, it includes discussion of the opportunities presented by the delay and AHIMA's recommendations for actions to maintain the momentum and position stakeholders to successfully transition to and implement ICD-10 on October 1, 2015.

Key words: ICD-10-CM; computer-assisted coding; clinical documentation improvement

Introduction

Since 2009, AHIMA has convened an annual ICD-10-CM/PCS Summit to help develop and lead an industry-wide plan and gain a strategic advantage from implementation of the new code sets. This event provides a forum for thought leaders from all segments of the healthcare industry, including providers, payers, vendors, consultants, and secondary data users, to engage in open discussion to better understand the perspectives of other stakeholder groups and to develop opportunities for collaboration and networking. Previous meetings have explored the challenges and opportunities of the transition to the ICD-10-CM/PCS (ICD-10) coding systems. The programs featured information, resources, and networking opportunities to help attendees effectively plan and manage the transition process.

In 2013, AHIMA combined its ICD-10-CM/PCS Summit and its Computer-Assisted Coding (CAC) Summit into one meeting and launched a related Clinical Documentation Improvement (CDI) Summit addressing clinical documentation excellence.

The goals of the 2014 ICD-10-CM/PCS and CAC Summit were to:

- Help attendees become better prepared for a smooth transition to ICD-10 and/or CAC
- Provide information to refine implementation strategies to leverage opportunities, mitigate risks, and employ data analytics to achieve high-quality clinical documentation and a successful, cost-effective transition

A program steering committee comprised of experts in the field set the meeting goals for the 2014 Summit, prepared the agenda, and made suggestions about discussion topics and presenters. The nearly 300 attendees included representatives from various segments of the health information management (HIM) and informatics fields, including providers, payers, consulting firms, industry, government agencies, and consumer advocates.

The meeting convened on April 22-23, 2014, in Washington, DC. Plenary sessions provided context for the discussions and helped participants to focus on key issues regarding coded data capture and documentation. Speakers included representatives from the Centers for Medicare and Medicaid Services (CMS), the National Center for Health Statistics, the American Medical Association, Cerner Corporation, Siemens HealthCare, and the CMS Office of E-Health Standards and Services. Plenary sessions were followed by breakout sessions including best practices for ICD-10 testing and implementation and successful approaches for natural language processing and CAC adoption.

The 2014 summit took place in the immediate aftermath of a Congressional action that delayed the implementation of the new ICD-10 code sets, which had been expected to occur in October 2014. The event served as an opportunity for industry leaders to discuss issues resulting from the delay, as well as other ICD-10 related issues. At the time of this event, no new ICD-10 compliance date had yet been announced.

This report presents findings and discussions from the 2014 summit and includes short-term issues related to the recent delay in implementation.

Background

In August 2008, the Department of Health and Human Services (HHS) published a notice of proposed rulemaking for adoption of the ICD-10 code sets to replace ICD-9-CM in HIPAA transactions, with a proposed compliance date of October 1, 2011.¹ The final rule was published in January 2009, with a final compliance date of October 1, 2013.² The compliance date was delayed from October 1, 2013, to October 1, 2014, by a final rule published on September 5, 2012.³ On April 1, 2014, the Protecting Access to Medicare Act of 2014 was enacted, which prohibited the Secretary of HHS from adopting the ICD-10 code sets as the standard for code sets prior to October 1, 2015.⁴

On May 1, 2014, CMS issued an announcement indicating that HHS expected to release an interim final rule in the near future that would include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. This rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015. At press time, an interim final rule has not been issued.

Opportunities for Leveraging ICD-10 Data

The transition to ICD-10 has been long anticipated by its advocates for a number of reasons. Anticipated benefits of using more robust, up-to-date code sets can be identified in the following areas:

Quality measurement

- Better data for evaluating and improving quality of care
 - Reduction in complications and improved patient safety
 - Improved patient outcomes
- Greater ability to measure outcomes, efficacy, and costs of new medical technology
- Greater ability to ascertain disease severity for risk and severity adjustment
- Greater ability to manage chronic diseases
- Public health
 - Enhanced public health surveillance
 - Greater ability to track and respond to global health threats
 - Facilitate international comparisons of quality of care and global sharing of best practices
- Research
 - Code analysis is essential to research when direct access to patient records is not possible
 - Data could be used in more meaningful way to enable better understanding of complications, better design of clinically robust algorithms, and better tracking of the outcomes of care
 - Greater detail offers the ability to discover previously unrecognized relationships or uncover phenomenon such as incipient epidemic early
 - Expanded injury research and successful injury prevention strategies
- Organizational monitoring and performance
 - Administrative efficiencies
 - Cost containment
 - More accurate trend and cost analysis
 - Improved ability to analyze trend and cost data
 - More effective monitoring of resource and service utilization
 - Reduced submission of medical record documentation to support reimbursement claims
 - Reduced reliance on manual medical review
 - Improved coding accuracy and productivity
- Reimbursement
 - More accurate and fair reimbursement
 - Better justification of medical necessity
 - Fewer erroneous and rejected claims
 - Increased sensitivity when making refinements in applications such as grouping and reimbursement methodologies
 - Reduced opportunities for fraud and improved fraud detection capabilities
- Health information technology
 - Realize benefits of SNOMED-CT and interoperable health data exchange
 - Facilitate electronic data retrieval
 - Expanded computer-assisted coding technologies
- Health policy and strategy
 - Improved information for setting health policy
 - Better data for operational and strategic planning
 - Better data for designing healthcare delivery systems

Challenges and Risks to Achieving Timely ICD-10 Readiness

There are tensions across the community between those users who say that they are ready to implement the new code set and those who are not. Some providers continue to cite examples about potential significant administrative burdens and costs related to code set implementation. In general, clinicians prefer to spend their time on patient care and are concerned if they spend excessive time and/or efforts on unnecessary largely administrative tasks that detract from care. However, improved work processes, overall systems design, and better user interfaces will help address such concerns.

There is a risk that an extension in the ICD-10 compliance date will not ensure widespread industry readiness. As has been observed with previous delays in ICD-10 implementation, extra time does not necessarily guarantee that all entities will achieve readiness by the new compliance date. There are concerns that rather than using the extra time to their advantage, entities that have consistently been behind in preparedness may continue to lag behind. In addition, some entities that were on track to meet the 2014 compliance date may fall behind, due in part to these possible challenges and risks presented by the delay:

- Loss of momentum
- Loss of stakeholder attention and focus
- Redirection of ICD-10 budget (some organizations' ICD-10 budgets were never completely restored after the last delay)
- Diversion of personnel to other projects
- Declining physician interest and engagement
- Maintaining coders' ICD-10 skills until the compliance date
- Loss of coding staff as individuals retire before ICD-10 is finally implemented
- Increased implementation costs
- Skepticism regarding firmness of next compliance date
- Hired or contracted staff brought on board for ICD-10 work needed during final stages prior to compliance date who are now no longer needed until next year
- Uncertainty regarding the impact of the delay on the partial code set freeze
- Persistent myths, misinformation, and unsupported hypotheses regarding issues such as "alternatives" to ICD-10 adoption (i.e., SNOMED-CT, ICD-11), projected coding accuracy and productivity impacts, and implementation costs and complexity, which detract from industry focus and commitment to ICD-10 transition preparation

Continued delay in transitioning to ICD-10 also leads to risks associated with lost opportunity costs. In addition to the direct costs of any further delay, significant ongoing costs are being incurred because of the failure to replace the ICD-9-CM code set. Continued use of the out-of-date and imprecise ICD-9-CM code set results in costs associated with:

- Inaccurate decisions or conclusions based on faulty or imprecise data
- Administrative inefficiencies due to reliance on manual processes
- Coding errors related to code ambiguity and outdated terminology
- Worsening imprecision in the ICD-9-CM code set due to the inability of the structure to adequately accommodate requested modifications, exacerbated by the partial code freeze that has been in effect since 2011⁵

General Discussions and Findings

Based on the content of summit presentations and commentary from audience members, we can draw a number of conclusions, observations, and key findings.

General

- ICD-10 should be used as a platform to drive organizational change.
- ICD-10 is the foundation for many other healthcare initiatives. It serves as a tool to:
 - Measure the quality of care delivered
 - Improve performance
 - Expand community health initiatives
 - Prevent fraud, waste, and abuse
- The better data provided by ICD-10 will lead to better insights about health conditions and care management, better predictive analytics, and ultimately better health outcomes.
- The value of ICD-10 data needs to be clearly articulated to all ICD-10 stakeholders.
- Since the cited benefits of the transition to ICD-10 are largely intangible, skeptics have been difficult to convince that implementing ICD-10 is worthwhile.
- To shift the mindset of those who don't see value in the ICD-10 transition, start by aligning the organization around ICD-10. To demonstrate value, use data to predict trends and set goals, take actions based on these trends, and measure success.
- The results from one payer's ICD-10 testing project revealed a significantly higher DRG variance rate when natively coded claims were used as compared to claims created using equivalence maps, suggesting that use of natively coded claims for testing and data analysis purposes is preferable because it provides a more accurate picture.⁶ This same payer also found that coding errors were the greatest driver of DRG variances, use of contract coders resulted in more coding errors than when claims were coded by a provider's own coders, and providers with coders who had greater ICD-10 coding experience produced fewer coding errors.⁷ These findings highlighted the value of comprehensive ICD-10 education for coders.
- Physician engagement is crucial to a successful ICD-10 transition.
- Many providers and physicians see the value in moving ahead to ICD-10 and were disappointed by the delay. They were prepared to meet the 2014 compliance date and will face increased implementation costs as a result of the delay. Furthermore, a number of physician organizations contributed to the content of ICD-10.
- The transition to ICD-10 will result in some data trending changes, but this is to be expected. If there were not significant differences between the old and new code sets, there would be no reason to implement the new code set.
- Using natively coded cases should be the "gold standard" for ICD-10 planning, preparation, and testing purposes. General Equivalence Maps (GEMs) are intended for converting large databases to ICD-10 or for limited circumstances when natively coding clinical documentation is not possible.

State of ICD-10 Readiness

- Many healthcare organizations expected to meet the 2014 compliance date and were very disappointed and frustrated by the Congressional action delaying the ICD-10 transition.
- Despite popular opinion to the contrary, most state Medicaid agencies were prepared to meet the 2014 compliance date.
- CMS was also ready for the 2014 compliance date.

Delay in Compliance Date

- Most summit participants appeared to be “staying the course” in terms of their ICD-10 preparation strategy, with some minor tweaking as a result of the delay.
- Despite its unexpected nature, the delay is not a “momentum breaker” for CMS, commented speaker Denise Buening, acting deputy director for CMS' Office of E-Health Standards and Services during the summit. “Extension” may be a better term than “delay” to describe the change in the ICD-10 compliance date, Buening said.
- Summit participants had the opportunity to offer their views on the delay via a real-time poll. The vast majority of respondents to the poll (88 percent) were disappointed in the delay action. A significant number (42 percent) indicated their organizations had already spent more than \$1 million on ICD-10 implementation.
- It is imperative that there be no further delays in ICD-10 implementation in order to control implementation costs, as well as to start realizing the benefits of better data.
- Payers, providers, and vendors should stay the course and be fully committed to be prepared for the new compliance date so that another delay is unlikely.
- It is preferable for organizations to keep moving forward with ICD-10 transition planning and preparation at a slower pace than to stop altogether and then pick up the pace closer to the new compliance date, as trying to catch up later is potentially a more costly and less effective approach and increases the risk of not being ready in time.
- Participants expressed uncertainty as to whether there are likely to be any changes to the implementation requirements for a new compliance date, such as a staged implementation (i.e., not all providers implementing ICD-10 at the same time) rather than a single compliance date for all HIPAA-covered entities. The vast majority (91 percent) of respondents of the real-time poll conducted at the summit were opposed to a staged implementation.

Education

- ICD-10 education should be a major area of focus between now and the compliance date to minimize coding errors after implementation and to use findings from testing with business partners to identify opportunities to improve coding and documentation practices.
- Both summit participants and speakers observed that ICD-10 education has been shown to improve ICD-9-CM coding accuracy, reinforcing basic coding principles and strengthening foundational knowledge in biomedical sciences.
- Organizations should leverage technology to provide cost-effective education, especially for stakeholders with limited resources or time.
- Use of an encoder does not replace proper ICD-10 training.

- Physician education should be succinct. It should focus on clinical concepts, not coding rules and conventions, and tell physicians what they are specifically not documenting, not what they should be documenting.

Clinical Documentation

- Fee-for-service/volume-driven reimbursement is shifting to value-based purchasing where outcomes and cost are the focus. As a result, the importance of the accuracy and quality of data increases accordingly.
- Accurate data on severity, risk, quality, and outcomes depends on complete, accurate coding and documentation (i.e., “garbage in, garbage out”).
- Use ICD-10 to set the “gold standard” for clinical documentation.
- Non-specific documentation results in non-specific code assignments.
- The accuracy of CAC technology depends on the quality of underlying clinical documentation.
- Encourage physicians to focus their attention on patient care and documentation excellence. Focusing on the clinical elements needed for the ICD-10 code sets instead of coding principles/conventions will relieve much of physicians’ frustration with the ICD-10 transition.
- Incorporate ICD-10 compatible clinical terms into electronic health records.
- Leverage technology to provide “real time” documentation improvement tools to facilitate documentation capture at the point of care.
- Consider using mobile technology to provide physicians with customized lists of documentation tips.

Coding Accuracy

- Even today under ICD-9-CM, a summit speaker noted that coding accuracy appears to be in decline.⁸ Maps based on ICD-9-CM codes may lead to erroneous conclusions about the impact of the ICD-10 transition on data trends or revenue because of inaccurate ICD-9-CM codes. Inaccurate ICD-9-CM coding is one reason natively coding cases is preferable to reliance on maps for analyzing the impact of the ICD-10 transition. Providers should not assume ICD-9-CM coding is accurate and should audit ICD-9-CM coding and establish measures for productivity and accuracy.
- If coding accuracy is poor with ICD-9-CM, it is not likely to improve under ICD-10 without a training program that includes basic coding principles (“back to the basics” training) and strengthening foundational knowledge of biomedical sciences (e.g., anatomy and physiology, medical terminology).

Coding Productivity

- While many organizations are adopting CAC technology as an approach to mitigating the negative impact ICD-10 is expected to have on coding productivity, this technology should not be viewed as a “silver bullet.”
- Canadian coding productivity experience cannot be used for a realistic comparison of the impact of ICD-10 on US coding productivity because of differences in the code sets used, coding processes, and implementation approaches.
- A recent US ICD-10 coding productivity study revealed significantly less impact on outpatient productivity (6 percent decrease) as compared to inpatient productivity (64.5 percent decrease),⁹

providing solid evidence that outpatient settings can expect to experience a lower loss of productivity as a result of the ICD-10 transition.

- Early coder training with ongoing opportunities to reinforce knowledge (such as through dual coding) will improve coding productivity prior to ICD-10 implementation.
- Beware of outliers when analyzing productivity. Organizations should develop policies to guide coders in situations when they are spending an extensive amount of time struggling to come up with the correct code, as more time spent on the coding function does not necessarily mean higher coding quality.
- Addressing inadequate clinical documentation early will also improve coding productivity prior to the transition date.

Opportunities Presented by the ICD-10 Compliance Date Extension

Although many stakeholders are disappointed that ICD-10 will not be implemented this year, the extension presents a number of opportunities. It is an opportunity to reflect, regroup, and revitalize. The extra time offers the chance to “get the transition right” and mitigate risks caused by inadequate preparation. The main priorities suggested for organizational focus over the next year are documentation excellence, education, and testing.

Participants observed that many organizations did not leverage the opportunities presented by the last delay. It is now essential for organizations to take advantage of the opportunities provided by the current delay, including opportunities to:

- Increase engagement with physicians and their staff, ancillary departments, post-acute providers
- Evaluate and resolve ICD-9-CM coding and documentation issues
- Develop more thoughtful and comprehensive educational plans
- Focus intensively on coder education, continually enhancing skills, including ensuring coders have a solid foundation in basic coding education and biomedical sciences
- Reduce reliance on outsourced coding personnel, and thus decrease outsourcing costs, by using the extra time to train internal staff
- Shorten the coding learning curve by encouraging ICD-10 trained coders to continue to practice ICD-10 coding
- Continually assess and improve coding accuracy and productivity
- Analyze data to identify and focus on high-risk areas
- Consider implementing CAC technology if an organization has not already done so
- Validate CAC outcomes
- Allow CAC technology to be fine tuned and mature
- “Train” CAC tools and embed the use of this technology in workflows
- Conduct more robust testing
- Demonstrate the value of ICD-10 by using ICD-10 data from dual coding for tactical and strategic initiatives to identify health opportunities, to define and prevent readmissions, to analyze complications, and to identify ways the data will help improve patient care and community health

Recommendations

Based on the discussions at the ICD-10/CAC Summit, AHIMA makes the following recommendations to prevent another delay, maintain the momentum in planning and preparation, and position stakeholders to successfully transition to and implement ICD-10 on October 1, 2015.

Avoidance of Further Delay

- CMS should work with public and private sector organizations to broaden and deepen awareness of the appropriate use(s) of ICD-10 and to dispel the ongoing misunderstandings that exist regarding code set implementation.^{10, 11}
- Industry stakeholders should use actual data to start demonstrating the value of ICD-10.
- CMS and industry leaders should educate members of Congress and key White House staff on the value of ICD-10 as well as the adverse consequences of the current delay and any future delay.

Achieving a Successful Transition in 2015

CMS, Other Federal Agencies, Industry Stakeholders

- CMS and other industry stakeholders should continue to provide education on why moving to ICD-10 is important and should clearly articulate the benefits of moving to ICD-10 and demonstrate these benefits whenever possible.
- CMS should work closely with public and private sector stakeholders to ensure ongoing end-to-end testing for ICD-10.
- All industry stakeholders should use the current ICD-10 implementation delay to ensure organizational readiness and preparedness to implement ICD-10 no later than October 1, 2015.
- Industry stakeholders should “stay the course,” i.e., don’t cease or significantly slow implementation activities and expect to catch up closer to the compliance date.
- Stakeholders should collaboratively develop and launch a shared vision and common approach to facilitating and assuring the timely implementation of ICD-10.
- Stakeholders such as the ICD-10 Coalition¹² should collaborate closely to mitigate and address concerns about ICD10 implementation.
- CMS and stakeholders should offer training, education, and technical assistance, including the development of customized resources, to help “at risk” constituencies (such as small physician practices, rural providers, critical access hospitals) prepare for, achieve, and maintain readiness for ICD-10 implementation.
- Stakeholders should consider enlisting new HIM graduates to support their ICD-10 coding and transition preparation activities, as they have been trained in ICD-10 and are an excellent source of ICD-10 expertise.
- Healthcare organizations and educators should leverage the current heightened interest in the ways data can be used to improve healthcare to attract people to the health information management (HIM) and coding professions, thus alleviating anticipated future shortages in skilled personnel and expanding the HIM profession at a time when data analysis skills will be increasingly in demand.

AHIMA

- AHIMA should lead efforts to help ensure that public and private sector organizations, especially physician practices, have a thorough understanding of the impact, steps, and sequence needed for successful code set implementation, including “best practice” strategies, challenges and how to overcome them, and risk mitigation strategies
- AHIMA should lead stakeholder efforts to provide robust and focused for training, education and technical assistance for specific groups struggling to prepare for the ICD-10 transition, including physician practices, critical access hospitals, federally qualified health centers, and other small or rural providers.

Conclusion

In order for healthcare organizations to be prepared for ICD-10 implementation in 2015 and mitigate risks presented by the ICD-10 transition, it is imperative to “stay the course” and remain focused on planning and preparation activities. Top priorities over the next 15 months are achieving documentation excellence, providing education to coders, clinicians, data users, and other stakeholders, and conducting testing with business partners. Many ICD-10 preparation activities can provide value in advance of the transition to ICD-10. ICD-10 education for coders can improve ICD-9-CM coding accuracy, as “back to the basics” education reinforces knowledge of coding principles. Also, improving clinical documentation is essential regardless of the code set currently in use. Clinical documentation is necessary for supporting many healthcare initiatives, including improving the quality of care, lowering healthcare costs, measuring mortality risk and severity of illness, analyzing readmission rates, and meeting Meaningful Use requirements.

Avoiding further delay in ICD-10 implementation is critical in order to limit implementation costs and to be able to begin to leverage the opportunities anticipated by the availability of better healthcare data. Each delay is disruptive for healthcare delivery innovation, payment reform, public health, and healthcare spending.¹³ It is now more than 10 years since the National Committee on Vital and Health Statistics sent a letter to the HHS Secretary recommending the ICD-10 code sets be adopted as replacements for the ICD-9-CM code set and more than five years since the final rule adopting the ICD-10 code sets was published. The quality of healthcare progressively deteriorates as long as the US continues to rely on the outdated and imprecise ICD-9-CM code set.

Active engagement and commitment by all stakeholders are essential to preventing another delay and transitioning to ICD-10 smoothly. Dispelling persistent ICD-10 myths is a key element for achieving full stakeholder commitment to the ICD-10 transition. Therefore, CMS and other ICD-10 stakeholders have a shared responsibility to continually communicate the facts regarding the reasons behind replacing ICD-9-CM with ICD-10 and the actual impact of the transition on various stakeholder groups. The value of ICD-10 data must be clearly and consistently articulated to all stakeholders, and healthcare organizations should consider using the ICD-10 data they have begun collecting to conclusively demonstrate this value.

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Notes

1. Department of Health and Human Services. "HIPAA Administrative Simplification: Modification to Medical Data Code Set Standards To Adopt ICD-10-CM and ICD-10-PCS." *Federal Register* vol. 73, no. 164 (August 22, 2008). <http://www.gpo.gov/fdsys/pkg/FR-2008-08-22/pdf/E8-19298.pdf>.
2. Department of Health and Human Services. "HIPAA Administrative Simplification: Modification to Medical Data Code Set Standards To Adopt ICD-10-CM and ICD-10-PCS." *Federal Register* vol. 74, no. 11 (January 16, 2009). <http://www.gpo.gov/fdsys/pkg/FR-2009-01-16/pdf/E9-743.pdf>.
3. Centers for Medicare and Medicaid Services. "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 the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets." *Federal Register* vol. 77, no. 172 (September 5, 2012). <http://www.gpo.gov/fdsys/pkg/FR-2012-09-05/pdf/2012-21238.pdf>.
4. Public Law 113-93, 113th Cong. (April 1, 2014). Protecting Access to Medicare Act of 2014. <http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf>.
5. ICD-10 Coalition letter to Marilyn Tavenner, March 12, 2014. http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050620.pdf#xml=http://library.ahima.org/xpedio/idcplg?IdcService=GET_XML_HIGHLIGHT_INFO&QueryText=xPublshSite+%3csubstring%3e+%60BoK%60+%3cAND%3e+%28xSource+%3ccontains%3e+%60AHIMA+Testimony%2fComments%60++%3cAND%3e++xPubDate+%3e%3d+%6011%2f16%2f13+11%3a29%3a00+AM%60%29&SortField=xPubDate&SortOrder=Desc&dDocName=bok1_050620&HighlightType=PdfHighlight.
6. Parkany, Brian and Stacie J. Watson. "ICD-10 Collaborative Testing: Approach, Results, and Lessons Learned." Paper presented at the ICD-10/CAC Summit, Baltimore, MD, April 2014.
7. Ibid.
8. Neville, Deborah. "Life after the Transition: Next Steps." Paper presented at the ICD-10/CAC Summit, Baltimore, MD, April 2014.
9. Weems, Shelley, Pamela Heller, and Susan Fenton. "Results from the Veterans Health Administration ICD-10-CM/PCS Coding Pilot Study." Paper presented at the ICD-10/CAC Summit, Baltimore, MD, April 2014.
10. Medicare Learning Network. "ICD-10-CM/PCS Myths and Facts." April 2013. <http://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD-10MythsandFacts.pdf>.
11. Averill, Richard F., and Rhonda Butler. "Misperceptions, Misinformation, and Misrepresentations: The ICD-10-CM/PCS Saga." *Journal of AHIMA* web site, June 20, 2013. <http://journal.ahima.org/2013/06/20/misperceptions-misinformation-and-misrepresentations-the-icd-10-cmpcs-saga>.
12. Coalition for ICD-10. <http://coalitionforicd10.wordpress.com>.
13. ICD-10 Coalition letter to Marilyn Tavenner, April 11, 2014. <http://coalitionforicd10.wordpress.com/2014/03/26/letter-from-the-coalition-for-icd-10/>.

Additional Reading

AHIMA. "ICD-10." 2014. <http://www.ahima.org/topics/icd10>.

Averill, Richard, and Sue Bowman. "There Are Critical Reasons for Not Further Delaying the Implementation of the New ICD-10 Coding System." *Journal of AHIMA* 83, no.7 (July 2012): 42-48. <http://journal.ahima.org/wp-content/uploads/Critical-Reasons-for-Not-Further-Delaying-ICD10.pdf>.

Bounos, Maria T. "Evaluating Computer Assisted Coding Systems & ICD-10 Readiness." *Wolters Kluwer Law & Business*. http://www.wolterskluwerlb.com/health/files/1007-1/EvaluatingCAC_0611.pdf.

Bowman, Sue. "Why ICD-10 Is Worth the Trouble." *Journal of AHIMA* 79, no.3 (March 2008): 24-29. http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_036866.hcsp?dDocName=bok1_036866.

Centers for Medicare & Medicaid Services. "ICD-10." 2014. <http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10>.

Coburn, Tom, and Jason Fodeman. "ICD-10 Implementation Date: Better Never Than Later?" 2014. http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=60ddc053-2904-4d75-a160-62f64647b0bd.

DeAlmeida, Dilhari R., Valerie J. Watzlaf, Patti Anania-Firouzan, Otto Salguero, Elaine Rubinstein, Mervat Abdelhak, and Bambang Parmanto. "Evaluation of Inpatient Clinical Documentation Readiness for ICD-10-CM." *Perspectives in Health Information Management* (Winter 2014): 1-16. <http://perspectives.ahima.org/evaluation-of-inpatient-clinical-documentation-readiness-for-icd-10-cm/>.

DeCoster, C., Hude Quan, Alan Finlayson, Min Gao, Patricia Halfon, Karin H. Humphries, Helen Johansen, Lisa M. Lix, Jean-Christophe Luthi, Jin Ma, Patrick S. Romano, Leslie Roos, Vijaya Sundararajan, Jack V. Tu, Greg Webster, and William A. Ghali. "Identifying Priorities in Methodological Research using ICD-9-CM and ICD-10 Administrative Data: Report from an International Consortium." *BMC Health Services Research*, 6:77 (15 June 2006). <http://www.biomedcentral.com/1472-6963/6/77>.

e-HIM Work Group on Benchmark Standards for Clinical Coding Performance Measurement quality subgroup. "Collecting Root Cause to Improve Coding Quality Measurement." *Journal of AHIMA* 79, no.3 (March 2008): 71-75. http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_036926.hcsp?dDocName=bok1_036926.

Gemmell, Doris. "ICD-10 Debunked & Confirmed: Learning about ICD-10 from the Past, and the North." *Journal of AHIMA* 83, no.11 (November 2012): 34-37. http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_049803.hcsp?dDocName=bok1_049803.

Harris, Susie. "Implementing ICD-10: Lessons from the Field." *Perspectives in Health Information Management* (Winter 2012). <http://perspectives.ahima.org/winter-2012-introduction/>.

Jackson, Veronica E., and Alexander Muckerman. “Navigating Regulatory Change: Preliminary Lessons Learned During the Healthcare Provider Transition to ICD-10.” *Perspectives in Health Information Management* (Winter 2012): 1-20. <http://perspectives.ahima.org/navigating-regulatory-change-preliminary-lessons-learned-during-the-healthcare-provider-transition-to-icd-10-cmpcs/#.U2JTR1fqhVI>.

Moczygemba, Jackie, and Susan H. Fenton. “Lessons Learned from an ICD-10-CM Clinical Documentation Pilot Study” *Perspectives in Health Information Management* (Winter 2012): 1-11. <http://perspectives.ahima.org/lessons-learned-from-an-icd-10-cm-clinical-documentation-pilot-study/>.

National Center for Health Statistics. "International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM.)" 2013. <http://www.cdc.gov/nchs/icd/icd10cm.htm>.

Ross-Davis, Sydney V. “Preparing for ICD-10-CM/PCS: One Payer’s Experience with General Equivalence Mappings (GEMs).” *Perspectives in Health Information Management* (Winter 2012): 1-24. <http://perspectives.ahima.org/preparing-for-icd-10-cmpcs-one-payers-experience-with-general-equivalence-mappings-gems/>.

Sand, Jaime N., and Patt Elison-Bowers. “ICD-10-CM/PCS: Transferring Knowledge from ICD-9-CM.” *Perspectives in Health Information Management* (Summer 2013): 1-16. <http://perspectives.ahima.org/icd-10-cmpcs-transferring-knowledge-from-icd-9-cm/>.

Sanders, Tekla B., Felicia M. Bowens, William Pierce, Bridgette Stasher-Booker, Erica Q. Thompson, and Warren A. Jones. “The Road to ICD-10-CM/PCS Implementation: Forecasting the Transition for Providers, Payers, and Other Healthcare Organizations.” *Perspectives in Health Information Management* (Winter 2012): 1-15. <http://perspectives.ahima.org/the-road-to-icd-10-cmpcs-implementation-forecasting-the-transition-for-providers-payers-and-other-healthcare-organizations/#.U2JS1FfqhVI>.

Topaz, Maxim, Leah Shafran-Topaz, and Kathryn H. Bowles. “ICD-9 to ICD-10: Evolution, Revolution, and Current Debates in the United States.” *Perspectives in Health Information Management* (Spring 2013): 1-18. www.ncbi.nlm.nih.gov/pmc/articles/PMC3692324/.