

**Testimony of the  
American Health Information Management Association  
to the  
National Committee on Vital and Health Statistics – Standards Subcommittee  
by  
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## **Introduction**

Dr. Suarez, Mr. Soonthornsima, members of the subcommittee, ladies and gentlemen; good morning. I am Sue Bowman, senior director of coding policy and compliance for the American Health Information Management Association (AHIMA), and I have been asked to comment this morning on the issue of “New uses for the ICD-10 data.”

For those of you not familiar with AHIMA, we are an 85 year-old not-for-profit association of professionals, educated, trained, certified and working in the field of health information management (HIM). With more than 67,000 members in the United States, HIM professionals work in over 40 employment types associated with our nation’s healthcare industry in some 50-plus job types. HIM professionals subscribe to the principles of commitment to the patient, data integrity, and data confidentiality and these principles are the foundation for our comments today.

AHIMA and its members have been involved in various aspects of classification and terminology standards and systems and use of these standards and systems for many decades. Our work has also included the integration of terminology and classification standards into transactions and communication standards and operating rules. AHIMA and its members are active in a variety of standards development organizations including Health Level 7 International (HL7), ISO 215 Technical Committee for Health Informatics (ISO 215) and the US Technical Advisory Committee, the International Health Terminology Standards Development Organization (IHTSDO), and the World Health Organization Family of International Classifications (WHO-FIC) where I serve as the secretariat for the ICD-11 Morbidity Topical Advisory Group.

Since the 1960s, AHIMA has been a member of the Cooperating Parties for US use of ICD classification systems along with the American Hospital Association (AHA), the Centers for Disease Control and Prevention (CDC), and the Centers for Medicare and Medicaid Services (CMS). AHIMA also serves on the editorial boards for ICD-9-CM, ICD-10-CM/PCS, HCPCS, and CPT®. In addition, AHIMA is the designated secretariat for the ISO-215 and the US-TAG.

## **Comments**

### **New or Delayed Uses**

Given AHIMA’s historic involvement in health information and data, the topic of “new uses for ICD-10” is somewhat amusing. AHIMA has been active in the development of, and then promotion of the adoption, implementation, and use of ICD-10-CM, and ICD-10-PCS, since the 1990s. This involvement occurred early on because AHIMA recognized that the ICD-9-CM classification system could not meet the required uses for reimbursement and could not represent the clinical knowledge, procedures, and

disease complications on a contemporary basis. It was clear that as more codes were requested by US medical pioneers and specialists, the ICD-9-CM classification could not keep up with an accelerating body of knowledge regarding disease and technical improvement, as well as the need for more detailed knowledge for research and community health improvement.

The knowledge that ICD-9-CM was not meeting the needs of the US health system increased with the international adoption and implementation of ICD-10 and modifications of ICD-10 in other countries. So, when we look at “new uses,” we have to consider that many of the uses we see for ICD-10-CM and PCS are not new, but rather will be accessible to the US healthcare community with the final implementation and use of ICD-10-CM/PCS. Indeed, with a moratorium on further expansion of ICD-9-CM, I anticipate a considerable demand for new codes once ICD-10-CM/PCS is implemented and the 3-year moratorium lifted.

### **Parallel Development**

The final implementation of ICD-10-CM/PCS has been paralleled by the increased adoption, implementation, and use of electronic health records (EHRs) and incentive programs such as the ARRA-HITECH Meaningful Use. Further development and implementation of electronic health information exchange (HIE) will also permit additional or improved use of ICD-10-based information over time. Standardization of such uses will assist in the interoperability of health information.

The use of ICD-10-CM/PCS also lends itself to the process of computer-assisted-coding, such that as EHR systems become more standardized and use terminologies such as SNOMED-CT® or LOINC, the ability to automatically generate codes from the EHRs will change the process of coding as we know it today. Obviously, there is some concern regarding the mapping from the terminologies in the EHR to ICD-10-CM/PCS, and this effort will continue under the auspices of the National Library of Medicine.

### **ICD-10-CM/PCS are Tools**

ICD-10-CM and PCS are communication tools and as noted above these tools have far more uses than just reimbursement. Under coding requirements and ethics, a coding process, and the codes generated by the process, can only represent the information or data available in the health record, be it paper or electronic. The added detail of ICD-10-CM/PCS over ICD-9-CM requires more attention to the data that must be contained in the record. To this extent, use of ICD-10-CM or PCS requires more specification and detail be generated, by the clinician, than has occurred in the past. It is meeting this specification requirement that permits the greater use of the classification system itself and permits the expansion of use of the data in the record.

ICD-10-CM is based on the international WHO ICD-10 coding system. ICD-10-CM contains much more information than ICD-10, due to US health information needs and industry demands for additional detail as a result of the extensive uses of coded data in this country. In spite of this difference, having this relationship further permits the exchange of information internationally, which in turn provides the opportunity for greater and more efficient research, as well as public health information exchange and biomedical surveillance. In addition, the US has used ICD-10 for national and international reporting of mortality since 1999; and with the use of ICD-10-CM will soon be able to compare mortality and morbidity data in a much easier process. Ironically, over the past several years there have been times when the US mortality reporting was therefore much more accurate than our morbidity reporting.

## Uses

Given the limitation on time today, I can only give a high level view of potential uses for ICD-10-CM and PCS. Each one of these categories could be the topic for a hearing themselves, and since the clinical record system is the source of all the data, in the form of ICD-10-CM/PCS there is considerable overlap in the potential uses, with one use often supporting another. Additionally, to truly understand the possibilities for use of the ICD-10-CM/PCS classification systems, we should go into a detailed look at the structure or architecture of the classification systems, which time will not permit today.

### **A reimbursement system?**

ICD-9-CM was put in use in 1979. Three years later the Health Care Financing Administration (now CMS) decided to use diagnosis related groups (DRGs) as the basis of its prospective payment system and ICD-9-CM became a mechanism for claims adjudication. For much of the time since the early eighties ICD-9-CM changes have been announced as part of the annual update to the Medicare inpatient prospective payment system and therefore, many in the healthcare industry view the ICD-9-CM as a reimbursement classification system, not one intended for a much larger role in public health, research, quality measurement, and so forth. With this in mind, the National Committee on Vital and Health Statistics (NCVHS) might consider suggesting that the Department of Health and Human Services consider using a mechanism other than the Medicare inpatient reimbursement rule to announce changes to the diagnosis and procedure reporting systems.

### **Analytics**

Essentially, classification codes can be thought of as either a reporting mechanism with a one-time use, such as claims documentation for payment, or as a set of data, that can be analyzed either on an individual or group longitudinal or horizontal basis. In this latter case, data for analysis can be used for many purposes, internal and external, related to an individual patient or some grouping of patients. The same data might be used for more than one purpose or the purpose might change over time.

### **Quality**

In recent years attention has been placed on healthcare quality, to improve the health of the individual and the community; improve patient safety, and reduce the cost of healthcare delivery itself.

Healthcare providers have the opportunity to use a collection of ICD codes to determine the progress of an individual over time, measure the effectiveness of various treatment modalities, and so forth. Aggregating data from multiple patients using a single or multiple ICD codes can also provide information on best practices and other means of improving quality. On a community basis, these same collections of data in the form of ICD codes can provide for a larger analysis of treatment protocols, provider quality, and so forth.

As we have seen, these uses of ICD codes or quality measures that include ICD codes have resulted in quality comparisons of providers and the basis for measurement of quality for payment. The additional detail of ICD-10-CM/PCS makes this practice even better since the new classification system reflects the use of modern technology, the ability to better understand the processes and technologies uses, and the identification of more personal factors such as severity, co-morbidities, and so forth. The recent upgrading of the ASC X12 HIPAA administrative standards as well as other non-X12 clinical transaction standards allows for even more accurate analysis.

With the introduction of ARRA-HITECH, we also see the larger community looking to coded data to determine best practices across the healthcare industry that could result in the sharing of more effective and cost-conscious treatment specific to the patient's disease state or clinical situation.

There are multiple projects underway by organizations like the National Quality Forum (NQF), the National Committee for Quality Assurance (NCQA), CMS, and similar groups and health plans that I am sure various members of the subcommittee are aware. From our work, AHIMA believes this development of measures will only expand and we are working hard to ensure continuity among the nomenclature and use of these measures. I have to remind the subcommittee, however, that these measures that integrate ICD-10-CM or PCS codes are by the nature of coding relying on the documentation that has been placed in the record, which brings the issue of use back to documentation improvement.

### **Reimbursement**

The upgrading from ICD-9-CM to ICD-10-CM or ICD-10-PCS does not mean that the improved classification system will not be used for reimbursement purposes. On the contrary, the ICD-10-CM/PCS provides for more detail on which to determine payment policies and reimbursement under existing reimbursement programs as well as new reimbursement systems based on quality measurements and outcomes, or value-based purchasing. Pilots for these and other reimbursement systems are already underway and as noted, the added detail requirements for ICD-10-CM or PCS have been argued as a reason not to implement the new classification system; an argument that conflicts with the desired outcome of improved quality and decreased costs. Included under the area of reimbursement are also a number of value-based purchasing related requirements and the potential that ICD-10-CM or PCS information could also affect programs such as accountable care organizations (ACOs), bundled payments, and so forth.

### **Fraud and Abuse**

AHIMA has argued that correct use of ICD-10-CM and PCS should eliminate cases of fraud and "abuse" because the significantly more detailed coding system permits less guesswork on the part of the coder. Of course this goes back to assuming that clinicians are documenting their diagnoses, treatment, and other ancillary factors as part of their practice. Nevertheless, a qualified coder using ICD-10-CM or PCS should also be identifying where records are lacking the information needed for coding and therefore affect ongoing improvement in both clinical documentation and coding for the organization.

The use of ICD-10-CM and ICD-10-PCS has the potential to reduce the opportunities for fraud and improve fraud detection capabilities. Translating the terminology used in medical record documentation to terms with standardized definitions reduces coding ambiguity and misinterpretation, and thus improves coding accuracy and the ability to effectively audit claims. The increased specificity of the codes will make it easier to compare reported codes with clinical documentation, check for consistency between diagnosis and procedure codes, check for illogical combinations of diagnoses, and compare practice patterns across providers. There are fewer "gray" areas in coding (due to the increased specificity and use of standard definitions), and it will be more difficult for dishonest providers to hide behind ambiguities in code descriptions or rules (for example, under ICD-9-CM, it would be easier to use ambiguous code definitions to report a more complex procedure than the one that was actually performed). The improved logic and increased specificity in ICD-10-CM and ICD-10-PCS will facilitate the development of sophisticated tools for detection of questionable patterns and suspected fraud.

## **Audits**

Besides the internal use of ICD-10-CM or PCS data for quality improvement or correct coding of admissions or encounters, the more detailed coding system will lend itself to better internal or external auditing, again presuming the appropriate documentation. Providers who take active steps to implement internal audit programs should see a decrease in requests for external auditing as internal claims processing improves with the use of ICD-10-CM or PCS.

Audits often begin with a request for more detail as part of the adjudication system, which in turn calls for more administrative work on behalf of the provider no matter whether a record system is paper, electronic, or a hybrid of the two. The ability of health plans to now collect more diagnosis and procedures codes, due to the recent HIPAA transaction improvements, we believe will cut down on both the need for and the response to calls for more submission of medical record documentation or general use of “claims attachments.”

## **Clinical Care**

Oddly enough, while ICD classifications were built for external reporting, as I indicated, there are a variety of uses for the classification system internal to a provider that can be used in the provision of clinical care (decision support), disease management programs, patient safety, and so forth. I have already provided some examples for internal quality measurement and clinical decision making following a provision for internal utilization review. While further development of EHR systems based on terminologies will allow for even more analysis, a more generalized use of ICD-10-CM/PCS will allow less sophisticated EHRs or even paper systems to develop analysis programs to improve care and develop best practices. Improved ICD data will permit improved identification of patients for disease management programs and more effective tailoring of these programs to meet individual patient needs, thus improving patient outcomes, patient satisfaction, and lowering healthcare costs.

On a similar note, health plans using a clinical management system for subscribers can also make use of the coded information, such that requests for post acute placement or a revision of a post acute or long term care decision can be managed and used by clinical personnel. Longitudinal data on a patient can also provide either a provider or plan with information that can serve to make initial placement or coverage decisions. I am not suggesting that ICD-10-CM or PCS codes contain all the data necessary for all such decisions, but I am suggesting that the additional detail can allow for some initial decisions. Likewise, accumulated quality information or measurement of a provider’s will allow other providers or plans with some sense of the provider’s quality of care and other factors.

While some might see these potential uses of ICD-10-CM/PCS data as interference in the making of clinical decisions when the decision is made by a second party – health plan or consumer – this is exactly the use that was in mind in the development and use of these systems to meet the national goal for improved quality and decreased costs.

From a consumer perspective, ICD-10-CM or PCS data can also allow the individual to choose a primary, secondary, or other type of provider. Already, data in websites such as Hospital Compare is being accessed by individuals determining where they want to obtain care. Again, the ICD-data is only a product of the information in the health record, so providers must be aware of the impact of their decision on what to include in the patient’s record.

Lastly, for today's discussion, ICD-10-CM or PCS can provide more data for general clinical care for instance by providing details such as the patient's number of weeks of gestation of pregnancy for obstetric providers and the specific anatomic location for surgeons and similar clinical staff.

## **Public Health**

The ICD classification system was initially designed to support the improvement of public health. Unfortunately, this role has been ignored in recent years in part due to the continued use of ICD-9-CM and the delay in EHR systems adoption by providers and public health agencies. Imagine the potential for public health agencies to track disease outbreaks (in both morbidity and mortality systems) to alert the public and access collective data world-wide. This can be accomplished by flagging specific ICD-10-CM codes or combination of codes that can be sent electronically (HIE) from providers to the public health agency. Such surveillance might be initiated by an alert by the agency in the form of information to determine which codes within the coding system should be flagged. An individual whose codes are identified could receive immediate treatment (given the public health system) and the agency can be alerted with information that will identify where the outbreak may have occurred. None of this is readily available today but could be identified shortly as EHRs systems are implemented and HIE organizations established.

In addition to allowing for surveillance systems, having a classification system that is both internationally based and interoperable allows for the exchange of public health information quickly to identify new disease outbreaks and the ability to share data that can result in treatments to stop such outbreaks, based on data accumulated worldwide. This is another parallel system being developed.

## **Research**

Research use of diagnostic or procedure codes is not new. What is new is the ability to narrow the data being collected due to the more specific and logical classification system, and the inclusion of coding that reflects contemporary medical knowledge and updated disease codes in a proper order. For instance, oncologists will be able to (with expanded codes) look at specific types of various cancers and not just a generalized code. Cardiologists will likewise find more specific detail. ICD-9-CM codes have been so generic that researchers must access more data from the health record, which will not be needed once ICD-10-CM and PCS are in place. Better understanding of diseases and injuries will lead to improved prevention or mitigation strategies. ICD-10-CM will open new opportunities in injury research and trauma services evaluation. To further injury research, it is necessary to be able to accurately classify the nature of the injuries sustained and correlate the nature of injury with the mechanism of injury and outcome. ICD-10-CM would greatly improve the ability to accomplish this task. Clinically robust algorithms to treat chronic diseases and track outcomes of care can be designed. As noted under public health, the fact that ICD-10-CM is related to the international version of ICD-10 also means the ability to share data with international colleagues in a much more efficient manner, and better be able to analyze patient outcomes and treatment effectiveness globally.

## **Administrative**

I have continually noted that one of the goals for our nation's health care delivery system is to cut the cost of care. In several of the uses I have noted, the administrative value is obvious. More specific coding means less need to have to provide additional information for a claim, an audit, a research program, and so forth. Improvement in the documentation and coding process can mean less auditing and the withholding of reimbursement during a prolonged adjudication process. There are also savings to be had

from more informed clinical care and decision making, as well as the development of best practices internal to a practice or organization as well as for overall health improvement due to the analysis of population data, whether it is quality measurement, more rapid public health response, or similar programs to address patient safety, and so forth. Savings can also occur with improved documentation and audit procedures and potentially a limited need for external audits. Organizations can conduct more accurate and detailed trend and cost analysis, and more effectively monitor resource and service utilization.

Across the board the specificity of ICD-10-CM and PCS will provide more expedient data, and with improvements in quality measurement, patient safety, research, and public health, there should be an improvement in the population's health, and therefore the goal of reducing the overall cost of health care in the US will be closer to achievement

## **Consumer**

Over the last decade we have heard and established the goal of a consumer-centric healthcare system. I have already noted the ability of consumers to obtain and use data to compare the quality of care of providers. Beside this data, there is also underway the adoption of consumer-friendly interpretations of medical terminology including coded data. With better data will come an expanded ability to educate consumers on costs and outcomes of treatment options. While concern always arises regarding the literacy of consumers, this capability should likewise raise consumer awareness and involvement into their healthcare. As such ICD-based data can be included in patient portals and similar personal health information systems. Again, the premise is that increased patient understanding and involvement in their healthcare will improve the population's health and decrease the cost of healthcare.

## **Conclusion**

My testimony today is only a 50,000 foot perspective on the uses that can be employed around the use of the ICD-10-CM and PCS classification systems. There are many more examples and certainly many organizations engaged in developing more uses.

As I have also noted several times, the ICD classifications are tools that rely on documentation and on-going commitment to keeping the code sets consistent with the medical body of knowledge and the disease environment. Those who create or provide this documentation needed for the various uses discussed, must be committed to these uses and understand their personal role in providing the data and knowledge necessary for codes to be created and data integrity maintained. For far too long the use of ICD codes has been assumed by many to only serve as the basis for reimbursement. With ICD-10-CM and PCS classifications set to be in use in 15 months, it is time for a broader perspective on these uses and AHIMA wishes to thank the subcommittee for beginning this education today.

AHIMA looks forward to working with the NCVHS and HHS to further the understanding of the potential uses and benefits of ICD-10-CM and PCS information, and I am ready to take any questions the members of the subcommittee might have.

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