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Testimony to the National Committee on Vital and Health Statistics on International Classification of Diseases, 10th Revision (ICD-10-CM)

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National Committee for Vital and Health Statistics

Public Testimony on ICD-10-CM

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Good Morning----

My name is Louise Smith, and I am a registered Nurse who works as the Manager of Regulatory Assessment and Operations in the Regulatory Affairs Department at McKesson Information Solutions, which is a wholly-owned subsidiary of McKesson Corporation. McKesson Corporation is a Fortune 35 corporation, the world's largest supply management and healthcare information technology company. McKesson provides supply solutions and information solutions across the entire continuum of healthcare, including market-leading businesses in pharmaceutical and medical-surgical distribution, automation, information technology and outsourcing services for healthcare providers and payors.

McKesson Information Solutions' software applications include enterprise-wide patient care, clinical, financial and strategic management of software, as well as Internet-based and networking technologies, electronic commerce, outsourcing and other services to healthcare organizations throughout the world.

On behalf of McKesson Information Solutions, I thank you for this opportunity to provide comments regarding the implementation of ICD-10-CM.

McKesson Information Solutions' comments:

The approach to be used in this testimony is to first present the advantages in moving to the ICD-10-Clinical Modification System, followed by comments related to system modifications, the timing, other considerations, training implications and, finally, maintenance of this new code set. For purposes of the testimony the ICD-10-Clinical Modification will be referred to as "10-CM"

Benefits Associated with ICD-10-CM:

The structure of 10-CM appears to be logically organized and provides for greater clarity of coding diagnosis. For example, from review of the 1998 draft in the Endocrine, Nutritional and Metabolic Diseases chapter, the assignment of separate codes for Type I (the E10 category) and Type II (the E11 category) diabetes allows for greater specificity with a broader range of diagnosis codes to more accurately and precisely describe the diabetic conditions of the patient. The specificity will also allow for the use of fewer codes to describe a condition as well as additional DRGs to be developed to encompass more precise diagnosis of the patient.

Another benefit to the expanded number of diagnosis codes is that it can facilitate a more accurate collection of outcomes data by having greater exactness in linking patient diagnosis to outcomes. This can also lead to greater ability in measuring the effectiveness of the services provided and the management of disease processes as well as the safety and efficiency of care for a patient.

Finally, migrating to the 10-CM allows for an expansive comparison of medical data among countries in the world. Countries such as Australia, United Kingdom and Canada are already using ICD-10 for diagnosis, albeit a somewhat modified version.

Considerations Associated with Implementing ICD-10-CM:

We recognize the benefits of transitioning to 10-CM and would like to briefly point out that as a software system developer our role is not one of using the diagnosis data but rather implementing this new code set into software solutions for providers and payers.

From an information systems' perspective our interests rest in a large part to the software changes that will need to occur in software applications and supporting

documentation. These changes will be more thoroughly discussed later in the testimony.

It is important to note that given the importance and utilization of diagnosis coding the transition to a new coding system will result in significant changes for all organizations that make use of healthcare information and data. Product redesign will be required for diagnosis-based editing software. In addition, there will be an impact for the patient's longitudinal data.

In discussing the migration to 10-CM, McKesson as an information solutions provider looks at the 10-CM from a different perspective than would a clinician or medical records coder. Our interest in the diagnosis coding system is that as we provide software solutions to health care providers and payors, we want to be sure these software applications will enable the provider or payor to meet the defined industry standards.

Providers need the ability to view the codes on their computer terminals, to populate predefined tables with codes, to access those codes from defined tables and to have the ability to develop reports and perform ad hoc queries against databases that contain these codes.

Payor software systems need the ability to maintain the most current codes for their claims auditing, adjudication and reporting purposes as well as to maintain and have access to historical code sets for processing of claim appeals.

System modifications for migrating to a new diagnosis coding system:

It will be important for systems to maintain dual support of both the ICD-9-CM and ICD-10-CM code sets during the transition from 9-CM to 10-CM. Dual support will be required partly due to fiscal year considerations at each hospital or other healthcare entities as well as a need to validate older claims for reporting

purposes. In addition, historically it has been necessary to maintain an old coding system for some period of time until after it has been officially replaced by the new system. Consequently the maintenance and use of dual coding systems has to be accommodated by software products thus adding another dimension to the project and significantly impacting programming and testing time.

Since the 10-CM has expanded the numbering scheme from a 5-digit numeric to that of a 6 digit alphanumeric character, software applications that either capture, store, maintain, receive, send or edit against diagnosis will be required to modify the system field length in order to allow for the expansion of 10-CM. System modifications will need to occur in every location within the software where a diagnosis code currently exists. For Hospital Information Systems (HIS) this would include software applications for order entry, laboratory, radiology, pharmacy, medical records, patient care admitting, and patient accounting.

Coordination between code set modification and all applicable systems becomes a crucial component in the success of ICD-10 implementation. Today most hospitals use software applications from several different vendors. Therefore, the transition to 10-CM will necessitate software modifications to both the product applications and to the interfaces between the various applications and foreign systems.

Most hospital information systems will rely on the developers of grouper and encoder systems to provide file layout specifications and grouper software in a timely manner. Since the final version of 10-CM has not yet been released it is presumed that software system vendors will be designing and programming for this project at the same time that the vendors supplying the codes, groupers, encoding products and code mappers are developing their software. While some of this development can overlap there is still a need for the groupers and encoders to be completed early in the process to enable HISs the ability to code and test required changes from grouper programs. In addition, testing between

the different software vendors for integration purposes will need to occur to ensure against data integrity problems.

State reporting files such as Cost Containment, Discharge Reporting and other state specific files that utilize diagnosis codes or the output of such codes will also require modifications.

Payor software contains ICD-9 diagnosis tables that serve as a foundation to other applications. For this reason, the transition to 10-CM will require modifications not only to the field expansion and redefinition but also to the logic for fee schedule calculations and structure, authorization screens, DRG assignment and pricing interfaces, enrollment screens (which captures pre-existing diagnosis & procedures), claim screens (to accommodate the field size and field type change), and data abstracts that support utilization reporting. In addition, users will need to revise their configurations for health benefits and reimbursement. For many payor systems the clinical logic built into auditing functionality and statistical analysis will need to be assessed for revisions. Also, data repositories will need to be revised to accept the 10-CM data elements.

Decision support systems provide patient grouping capabilities through embedding the CMS DRG grouping or interfaces with other grouper software. Moving to 10-CM will require modifications to support the 10-CM as well as the same type of system changes as HIS systems for reporting and analysis functions which use the codes. Databases that have been created for modeling purposes will need to address issues of reporting current data versus historical data. Software system logic will need to be revised such that a determination can be made as to when to invoke mapping functions. Otherwise it will be difficult to perform comparative reporting when part of the population is under one code set and the rest of the population is under a different code set. There is also a need for the code mapping changes to be completed and available in a timely manner to support the software system changes.

Clearinghouses that translate nonstandard claim formats into standardized claim formats will be supporting a variety of input formats in addition to those mandated by HIPAA. Each of those formats as well as the programs that process them will require modifications for the field length/type changes. Remittance formats will also require changes. Typically, there are multiple programs that must be executed for a claim to go through production in a clearinghouse. Therefore, a change in a field size within a clearinghouse requires changes to several programs to allow field size changes to be passed on to other modules within the application.

For practice management systems used for claims processing that currently accommodate six character alphanumeric codes the modifications will be minimal due to the fact that many group practices use a limited range of diagnosis codes for billing purposes. Most physician practices will update their existing diagnosis code files with the new codes to insure compatibility with payor requirements and test ad hoc reports and any customized forms that print diagnosis.

Both end user and technical documentation will need to be developed to accompany the software system upgrade and implementation.

The amount of disk space required is difficult to predict since systems generally maintain ICD-9 codes by effective date and by payor. Adding 10-CM to existing maintained code sets potentially doubles the amount of space needed.

Timing:

The timing of ICD-10 implementation is a critical issue with regard to the Health Insurance Portability and Accountability Act ("HIPAA"). Currently information systems vendors, providers and payers have focused many resources toward meeting the compliance requirements with the transactions and codes sets as

defined under HIPAA final regulations. As you know, Congress passed the Administrative Simplification Compliance Act (ASCA) that will allow a covered entity to file for a year extension on the use of the standards and code sets mentioned in the Transactions and Code Sets Final Rule. The complexity of the new implementation period is more critical than ever with ASCA because some entities may choose not to file for the extension while others may file, which basically requires a pseudo-standard in the interim year. This complicates the implementation efforts of vendors and covered entities alike.

It would be desirable for an implementation of at least 3 years after the initial compliance date of the HIPAA transactions and codes sets (2002). This would allow the industry adequate time to design, code, and test the appropriate software changes and implement such system upgrades into provider and payer sites.

Other Considerations:

Although this hearing is focused on 10-CM, as an information system solution provider, the preference is to implement ICD-10 diagnosis (ICD-10-CM) and procedure (ICD-10-PCS) codes **concurrently rather than at different times.** This would help to avoid a burden being placed on providers, payors and software vendors in the maintenance of version control between the ICD-9-CM (procedures) and ICD-10-CM (diagnosis). In addition, the areas in the software that will need to be modified for diagnosis and procedures are the same; therefore it would be more efficient to make such software changes at the same time. For instance, using 10-CM for diagnosis and maintaining ICD-9 for procedures for the DRG calculations and the Medicare outpatient APC calculations will require grouper logic to recognizes both code sets and defined parameters in order to determine which code set should be used. Changes to the groupers are generally made once per year (sometimes quarterly for APCs). Mixing the two code sets adds further complications to both system functionality, design, coding and provider usage.

Software applications with reporting functions using HEDIS or ORYX information will need the clinical requirements from the National Committee for Quality Assurance and the Joint Commission before software changes can be made

Experience in Canada and Australia

In Canada our experience has been that of building the tables and setting parameters for the users to convert to ICD-10-CA (the Canadian modification of ICD-10). ICD-10-CA went into effect in April 2001. Currently 10-CA is not used for billing purposes; therefore, the actual code conversion to 10-CA is performed in the abstracting applications.

Our experience in Australia with ICD-10-AM (Australian modification) required us to modify tables for alphanumeric codes, for expanded field length and for storage of multiple codes per patient.

In the United Kingdom ICD-10 was developed in 1994 for use in 1995. The UK had a drop dead date of April 1, 1995. The UK uses the WHO version of ICD-10 with no clinical modification. Our UK division maintains and updates the ICD-10.

Our past experience in Canada, the UK and Australia has been that of being given at least a 12 month lead time to develop. However, for those countries the scope of the changes were less complicated than we anticipate in the U.S. This is due to the fact that there were no groupers or DRGs that factored into the picture but also due to the types of system applications in those countries.

Training And Resource Requirements:

Training is a requirement for software vendors as well as for providers and payors. It will be necessary for software developers/programmers to understand the new coding system to facilitate enabling applicable coding changes.

Resources needed to make the changes will vary depending on the type of system and on the extent of the changes. Surveys from among some of our various business units regarding resources were estimated to range from 24 man months to 180 man months, again depending on the software applications.

Public Maintenance Committee:

It is our opinion that the public maintenance of the diagnosis and procedure codes in place today works well. However, one suggestion we would like to make is that the CMS and/or NCVHS identify a group within the HHS Agency that can and will promptly respond to questions that may arise as software developers are writing functional specifications for the required software changes. This is especially critical for the initial implementation of the new coding system. Having a process such as this in place has already proven to be extremely beneficial.

When implementing the ICD-10CA in the Canadian market, we had specific questions regarding interpretation of information in an ICD-10CA file that we had received from the Canadian Institute for Health Information (CIHI). We had the ability to e-mail our questions and have responses promptly e-mailed back to us. We were also able to arrange conference calls with CIHI representatives when the need to have real time dialogue was evident. .

Another suggestion is that when codes are updated it is helpful to have a supporting document that outlines the specific changes. This document can be utilized such that it would eliminate the need to search through a long series of files to ascertain where changes occurred.

Summary:

In summary, we believe the migration to 10-CM will require a great deal of synchronization between the multiple players in the health care market segment, including software vendors, states for state reporting requirements, providers, payers, and third party processors. Additionally, the timing of the implementation

of 10-CM should be coordinated with the implementation of HIPAA such that the implementation occurs three years after October 2002, the earliest compliance date for transactions and code sets. We further believe that from a software perspective it would be a better strategy to implement the ICD-10 diagnosis and procedure codes at the same time rather than independent of each other.

On behalf of McKesson Information Solutions I would like to thank the subcommittee for this opportunity to present our comments.

Impact for Various Types of Systems

System Type	Minimal impact	Moderate impact	Substantial impact
Physician	X		
HIS		X*	X*
Payer			X
Compliance Auditing			X
Decision support		X	
Clearinghouse		X	

Minimum impact:

- Minimal programming and development time
- Minimum time for revising documentation, testing and integration with other software applications.
- Estimated timeframe: 2 FTEs for less than 12 calendar months

Moderate impact:

- Changes include developing new tables, new parameters, screen capture changes, interface changes, report changes.
- Revisions to documentation, testing & integration with other software
- Estimated timeframe: approximately 3 FTEs for 12-24 calendar months

*This may fall between moderate and substantial for some HISs

Substantial impact:

- Major system redesign
- Changes include developing new tables, new parameters, screen capture changes, interface changes, report changes.
- Requires revisions to documentation, testing & integration with other software, changes to clinical logic, new edit checks.
- Estimated timeframe: approximately 5 FTEs for 36 calendar months