



**Association of
American Medical Colleges**
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Via Electronic Submission (<http://www.regulations.gov>)

Michael O. Leavitt
Secretary
US Department of Health and Human Services
C/O Centers for Medicare & Medicaid Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE:

CMS-0013-P: HIPAA Administrative Simplification: Modification to Medical Data Code Set Standards To Adopt ICD-10-CM and ICD-10-PCS; Proposed Rule (73 Fed. Reg. 49706) (August 22, 2008) (the “ICD-10 proposed rule”)

CMS-0009-P: Health Insurance Reform; Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards; Proposed Rule (73 Fed. Reg. 49742) (August 22, 2008) (“the 5010 proposed rule”)

Dear Secretary Leavitt:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the on the above-referenced proposed rules. The Association’s Council of Teaching Hospitals and Health Systems (COH) comprises nearly 400 major teaching hospitals and health systems. The Association also represents all 130 accredited U.S. allopathic medical schools; 94 professional and academic societies; 90,000 full-time clinical physician faculty; and the nation’s medical students and residents.

The Association acknowledges that it is necessary to move from the current ICD-9 coding system to ICD-10 and that over time such a move will be beneficial to the overall health care system and to our members. However, there are significant challenges associated with making this change. Our physician group members point to the difficulties of moving from the unique physician identification number (UPIN) to the

national provider identifier (NPI), and have expressed skepticism about the government's ability to ensure a smooth transition to ICD-10. Given the enormity of the task being asked of providers—in terms of the amount of time needed, the number of individuals involved, and the cost—we believe it is only reasonable and fair that in the final rule HHS set forth a definitive list of outreach, educational, and other activities it will undertake to ensure that this transition is successful. We believe that this initiative will require resources at the level that were devoted to the Y2K project and urge the federal government to announce publicly and specifically its level of commitment. Further, the government must ensure that all parties—providers, payers, contractors, and vendors—are committed to the same timetable for implementation. If one part of the system is not ready, then the entire implementation is in danger of failing.

The ICD-10 proposed rule would replace the current ICD-9 clinical coding system with an updated and expanded coding set. The ICD-9 system, which has been in use for the past 30 years, is rapidly becoming obsolete as it is running out of coding spaces and cannot be expanded. This deficiency is of particular concern to teaching hospitals and clinical faculty who often develop the newest procedures and treat the most complex patients whose diagnoses cannot be fully captured under ICD-9.

The ICD-10 system is a greatly expanded code set that better reflects the current state of medical practice and is more adaptable to future changes. Although there will be no payment implications in the initial move to ICD-10, in the future it is anticipated that the additional codes in ICD-10 will ensure more accurate and better targeted payments for the services provided by hospitals and physicians, particularly for the new and cutting edge services and procedures that often originate in academic medical centers. Once the ICD-10 system is fully implemented, it should obviate the need for hospitals and physicians to provide additional documentation when submitting patient claims to payers and may reduce claims rejections and claims adjudication costs.

The first step in the transition to ICD-10 must be the successful implementation of the new electronic transaction standard (version 5010) as set forth in the proposed rule that was published on the same day as the ICD-10 proposal. Under the proposed rules, implementation of the 5010 rule would occur on April 1, 2010 and the ICD-10 systems would begin on October 1, 2011. Given, however, that a final rule has not yet been published, we believe these timeframes are unrealistic given the enormity of the task ahead. We urge the Agency to consider all of the comments received and revise the time frame accordingly.

Further, a successful transition to ICD-10 requires that HHS acknowledge the enormity of the effort that will be required of health care providers and the associated costs of this change. The costs of this implementation are definite and substantial. At the same time, delaying this transition will only result in higher costs later on. While there will be benefits to making this change in the long term, the extent and timeframe of these benefits are harder to quantify.

Because of their size and complexity, academic medical centers will be particularly affected by this transition. Teaching hospitals and their affiliated clinical faculty physicians provide countless services throughout a year in both inpatient setting and numerous clinics. Many already have invested substantial time and money in electronic health records that may need to be modified to accommodate a new set of codes. Further, academic medical centers have large clinical databases and registries that are used for research. It is critical that crosswalks between ICD-9 and ICD-10 not interrupt the use of these data, particularly if longitudinal data are involved.

Because of the complexity of their operations, we also believe HHS should pay particular attention to major teaching hospitals and their associate physician practices to ensure that any unique needs of these institutions are addressed expeditiously. We would be happy to work with the Department to develop and ensure that there are appropriate methods for communication.

Finally, every health care provider makes inadvertent errors in coding and billing. These routinely are corrected through the return of overpayments and adjustments for underpayments. HHS should work with its Office of Inspector General (OIG) and all Medicare and Medicaid contractors and auditors to ensure that during this transition these errors—which may be more frequent due to the lack of familiarity with the new system—are viewed as errors and, except in the most egregious instances, do not become the basis for claiming that the provider has violated the False Claims Act.

Thank you for this opportunity to present our views. We would be happy to work with the Department on any of the issues discussed above or other topics that involve the academic health care community.

If you have questions regarding our comments, please contact Karen Fisher at 202-862-6140, kfisher@aamc.org, or Ivy Baer at 202-828-0499, ibaer@aamc.org

Sincerely,

A handwritten signature in black ink, appearing to read "Joanne Conroy M.D.", with a stylized flourish at the end.

Joanne Conroy, M.D.
Chief Health Care Officer

cc: Karen Fisher, J.D.
Ivy Baer, J.D.