



Physicians Caring for Texans

May 11, 2012

Honorable Kathleen Sebelius  
Secretary  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

Re: File CMS-0040-P – 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 ICD-10-CM and ICD-10-PCS Medical Data Code Sets

Dear Secretary Sebelius,

The Texas Medical Association (TMA) appreciates this opportunity to comment on the Department of Health and Human Services' (Department) proposed regulation relating to the Change to the Compliance Date for ICD-10-CM and ICD-10-PCS Medical Data Code Sets.

TMA is a private, voluntary, nonprofit association of Texas physicians and medical students. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its mission is to "Improve the Health of all Texans." Its almost 46,000 members practice in all fields of medical specialization. It is located in Austin and has 119 component county medical societies around the state.

Consistent with its mission, TMA has a keen interest in advocating for laws and regulations promoting efficiency in the delivery of healthcare and economic viability of physician practices.

TMA appreciates the delay for ICD-10 implementation that is present in these rules. However, TMA is greatly concerned that eventual adoption of the ICD-10 data code sets will introduce great cost in terms of disruption and practice implementation without a corresponding benefit. TMA respectfully urges DHHS to forego the adoption of ICD-10 and instead either implement ICD-11 data code sets or SNOMED with an appropriate translator program for converting to ICD<sup>1</sup>, when these become possible. In the alternative, should the Department move ahead with ICD-10, TMA urges the ICD-10 implementation date be delayed by a period of greater than one-year.

TMA argues that the Department should recognize that the costs of going to ICD-11 directly are less than incurring the remaining costs of implementing ICD-10 in 2014 and then implementing

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<sup>1</sup> SNOMED as a possible alternative to ICD-10 or 11. SNOMED has been proposed as a Meaningful Use Stage 2 requirement and should be implemented by no later than Stage 3. It has much more support in the informatics community as a clinician-friendly system than ICD-10 and is intimately connected into ICD-11. With SNOMED and the use of Convergent Medical Terminology in a certified EMR, physicians could conceivably avoid the impact of the ICD-10 conversion altogether. Convergent Medical Terminology as defined by the National Library of Medicine, is "a set of clinician- and patient-friendly terminology, linked to US and international interoperability standards, and related vocabulary development tools and utilities. Developed by Kaiser Permanente over many years for use within its health IT systems, CMT now includes more than 75,000 concepts." It makes electronic conversions between SNOMED and ICD-10 or ICD-9 possible currently.

ICD-11 sometime soon thereafter. Further, the positive benefits from efficiencies obtained through automated electronic medical record (EMR) coding capabilities that will come with ICD-11 (and the accompanying savings) should be factored into the Department's decision-making. Despite claims to the contrary, EMR vendors are not, at this time, developing automated ICD-10 coding because they are instead focusing upon ensuring their systems meet Meaningful Use mandates. This makes ICD-10, in comparison to the eventual ICD-11 standard, much more inefficient and costly. Finally, physician practices do not have the capital to switch to ICD-10 for the relatively short period before the nation will want to convert to ICD-11. As a result, the nation will be locked into ICD-10 for a prolonged period of time.

TMA is not alone in this assertion. The distinguished authors of a *Health Affairs* article stated, "In sum, we contend that the ICD-10-CM conversion is expensive, arduous, disruptive, and of limited direct clinical benefit."<sup>2</sup>

What is meant by the authors of the *Health Affairs* article when they make the contention (with which TMA agrees) that the standard is of limited clinical benefit? They mean:

- A study concluded that ICD-10 codes were not an improvement over ICD-9 codes for capturing clinical data.
- An analysis of ICD-10 codes discovered ICD-10 focuses upon injury codes (which are subdivided by laterality and encounters) while a lower percentage (as compared to ICD-9 codes) is dedicated to diseases.
- The ICD-10 code set does not facilitate the collection of important genomic information and other discoveries made since ICD-10 was developed almost 30 years ago.<sup>3</sup>

There is no information at this time of which TMA is aware that *requires* conversion to ICD-10 before moving to ICD-11. Yet, ICD-10 adoption is proposed despite its shortcomings. Indeed, some member physicians believe that, based on their experience in system conversion, the transition from ICD-10 to ICD-11 may pose greater challenges than a transition from ICD-9 to ICD-11.

The United States did not adopt the ICD-10 coding system 20 years ago when the standard was state of the art. Now, it is nearing obsolescence. CMS should re-evaluate the utility of mandating physicians to use, at the end of this decade, an inefficient 30-year-old standard that is:

"... based primarily on the international version of ICD-10 that the World Health Organization published in 1990—more than two decades ago. Furthermore, this version evolved in drafting committees working from 1982, thirty years ago. In many areas, ...ICD- 10-CM is a definitive advancement over ICD-9-CM... However, the base knowledge structures of ICD-10-CM fail to reflect the knowledge gains of the twenty-first century. For example, ICD-10-CM incorporates no genomic information—so that when a woman receives a bilateral prophylactic mastectomy because of family history and the presence of the BRCA2 gene (a genomic variant that dramatically increases the risk of breast cancer), there is no mechanism for coding this genomic variant as an indication for surgery."<sup>4</sup>

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<sup>2</sup> Halamka, John D., *et al*, There Are Important Reasons For Delaying Implementation Of The New ICD-10 Coding System, *Health Affairs*, April 2012. vol. 31 no. 4: 836-842.

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

According to an article appearing in Healthcare Financing News, Christopher Chute, MD, DrPH, Chair of the ICD-11 Revision Steering Group at the World Health Organization, was quoted saying,

“ICD-11 will be significantly more sophisticated, both from a computer science perspective and from a medical content and description perspective.... Each rubric in ICD-11 will have a fairly rich information space and metadata around it. It will have an English language definition, it will have logical linkages with attributes to SNOMED, it will have applicable genomic information and underpinnings linked to HUGO, human genome standard representations. ICD-10, as a point of contrast, provides a title, a string, a number, inclusion terms and an index. No definitions. No linkages because it was created before the Internet, let alone the semantic web. No rich information space.”<sup>5</sup>

The adoption of a standard that is acknowledged to be on the brink of obsolescence will not bring a sufficient benefit in light of the cost, disruption, and man-hours that must be dedicated to ICD-10 implementation. TMA argues that the savings and benefits of adopting ICD-11 should be researched by the Department. At 77 Federal Register 22974, CMS states that “Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives.” TMA asserts that CMS has not sufficiently complied with the intent of these Executive Orders because it has not provided an analysis of skipping ICD-10 and either moving to either ICD-11 or SNOMED and requests the Department undertake a review of savings that would result from skipping ICD-10.

Based on the foregoing, TMA respectfully urges the Department to not adopt ICD-10, but instead to work on the adoption and implementation of either ICD-11 or SNOMED with an appropriate coding translator.

Once again, TMA thanks you for the opportunity to provide these comments. If you should have any questions or need any additional information, please do not hesitate to contact Mr. Lee A. Spangler, JD, TMA Vice President, Division of Medical Economics at TMA’s main number 512-370-1300.

Sincerely,



C. Bruce Malone, MD  
President, Texas Medical Association

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<sup>5</sup> Sullivan, Tom. [Could the U.S. skip ICD-10 and leapfrog directly to ICD-11?](http://www.healthcarefinancenews.com/news/could-us-skip-icd-10-and-leapfrog-directly-icd-11) Healthcare Finance News, February 16, 2012, found at <http://www.healthcarefinancenews.com/news/could-us-skip-icd-10-and-leapfrog-directly-icd-11> [last accessed May 4 2012].