

Summary of April 15-16, 1997  
Meeting of the Subcommittee on  
Health Data Needs, Standards  
and Security



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# Purpose of Meeting

- Receive input from users of classification systems, code sets, vocabularies and nomenclature
- Discuss implementation of HIPAA standards for code sets
- Consider both diagnosis and procedure code sets

# Testifying Panels

- Professional Health Care Providers
- Health Care Facilities
- Special Data Users
- Providers and Health Plans
- Public Health and Research
- Federal Agency Data Users
- Developers of Coding and Classification Systems

# Presenting Organizations

- AAHP
- AAP
- ACOG
- ADA
- AHA
- AHIMA
- AHCPR (now AHRQ)
- AMA
- ANA
- ANSI (Z16 Committee)
- AOA
- APA
- ASPEN
- CAP
- CNC
- CSTE
- ECRI
- FDA
- HCFA (now CMS)
- HIAA
- JCAHO
- MEDICODE
- MEDSTAT
- NACHRI
- NAHC
- NANDA
- NAPHSIS
- NCHS
- NCPDP
- OMAHA
- VA

# Areas of consideration

- What was currently in use, describing how used
- Recommend initial standard to use given the timeframe of HIPAA
- Recommend migration to ICD-10-CM by year 2000
- How to achieve simplification and retain medically meaningful information
- Input on how to maintain code sets
- Resource implications of changing to a new classification/code set

# Additional considerations

- Can one system serve most users?
- Use same disease classification for administrative transactions & statistical reporting
- Do current systems represent your discipline well?
- Problems with linking coded data
- Implications of these systems with the CPR
- Market acceptance for recommended systems
- How NCVHS can assist U.S. in development of international systems
- Single procedure classification consideration
- Requiring universal acceptance of code sets

# Systems currently in use

## Diagnosis reporting - ICD-9-CM

- Disease indexing
- Statistical reporting (public health; state/federal)
- Provider billing/reimbursement
- Disease staging
- Performance indicator measurement
- Longitudinal research
- HEDIS measures

# Systems currently in use

- DSM – mental health diagnosis
- SNOMED
- LOINC
- READ
- NDC
- NANDA

# Strengths of ICD

- Well known and used by many including:
  - ◆ Hospitals, physicians, other providers, payers, data system users
- Training/education methods in place
- International recognition/comparability, can map CM version back to the WHO version
- Data systems are set up to accept it
- Open system in the public domain
- Level of comfort high with ICD

# Weaknesses of ICD

- Not specific enough for all data user needs
  - ◆ Not enough clinical detail
  - ◆ Cannot classify severity of illness
  - ◆ Preventive medicine, home health, nursing users specific to needing more detail
- Lengthy timeframe to update/new codes
- ICD-9-CM running out of space to add new codes
- Use of ICD is not consistent by all (i.e., payers)

## Recommended initial standard

- Continue to use ICD-9-CM for diagnosis reporting
- Migrate to ICD-10-CM
- Combination of ICD-(n)-CM with other systems, such as DSM
- Use ICD with crosswalks/links to other systems such as SNOMED, LOINC, READ

# Implement ICD-10-CM by year 2000?

- Too ambitious timetable
- Need to evaluate ICD-10-CM
- Suggested thorough field testing and cost/benefit analysis
- Don't delay implementation of ICD-10-CM too long

# Administrative simplification vs. medically meaningful information

Suggestions included:

- Single classification
- Combination of classification systems to meet all user needs
- Single set of guidelines adhered to by all
- Thorough testing and cost/benefit analysis before implementation
- Use of modifiers to enhance data collection

# Coding guidelines

- Have one set of guidelines for all healthcare encounters instead of inpatient vs. outpatient
- Uniform adherence to coding rules by those assigning codes as well as users of data
  - ◆ Require all payers to abide by one set of rules published by official source
  - ◆ All payers must use and accept all codes in the code set and its guidelines without modification

# How to maintain code sets

- Public domain without copyright restrictions
- Use the current C&M process with annual/regular updates
- Allow all users to volunteer input including physicians, professional groups, users
- Responsive to all needs of the health care community (all users of the classification)
- Readily available to the public
- Government funded maintenance process

# Resource implications of implementing new code sets

- Training – coders, physicians, data users, etc
- Comprehensive system programming and conversions
- Proficiency level – learning curve
- Crosswalk and reporting to compare data across systems
- Resources to re-map rules and tables in systems
- Always weigh against benefits of change

# Summary conclusions of testimony

- Many different classification/data needs by users
- For reporting diagnoses, continue to use ICD
  - ◆ ICD-9-CM now, and move to ICD-10-CM following development and testing
- Public domain access to code sets (no copyrights)
- Open input and access to maintenance process
- Uniform coding guidelines, reporting requirements, and code acceptance by all users
- Cost/benefit analysis prior to move to ICD-10-CM
- Possibly have ICD link to other systems

# Other recommendations/feedback

- Change must be compatible to all payment systems (DRGs, APCs, other PPS, and others)
- One system may not serve all data users' purposes
- Consider all users, rather than just hospitals, in selection and implementation of code sets
- Use existing/proven coding systems
- Consider the impact of these systems as we migrate to the CPR