Charles N. Kahn III
President and CEO

May 17, 2012

VIA COURIER AND ELECTRONIC MAIL

Ms. Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Attention: CMS-0040-P
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Comments on Administrative Simplification: Adoption of a Standard for 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 Ms. Tavenner:

The Federation of American Hospitals ("FAH") is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, short-stay and long-term care hospitals in urban and rural America, which provide a wide range of ambulatory, acute and post-acute services. We appreciate the opportunity to comment to the Centers for Medicare & Medicaid Services ("CMS") about the referenced Notice of Proposed Rulemaking on Standard Unique Health Plan Identifiers, National Provider Identifier Requirements and the Change in Compliance Date for ICD-10-CM and ICD-10-PCS ("Proposed Rule").

Unique Health Plan Identifiers (HPID).

The Affordable Care Act (ACA) requires the establishment of a unique health plan identifier by October 1, 2012. The FAH appreciates the discussion in the Proposed Rule of the purposes for such an identifier and the proposed structure of the HPID. We share the concerns raised by many during the stakeholder discussions at the National Committee on Vital and Health Statistics (NCVHS) regarding the importance of a smooth transition from current plan identifiers to the HPID. The Proposed Rule calls for an implementation date of

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October 1, 2012, with a compliance date of October 1, 2014. The FAH encourages CMS to test the functionality of the HPIDs during this transition period.

Other Entity Identifier (OEID)

The CMS proposes to add an identifier for Other Entities in the health care system, entities who "are not health plans, health care providers or "individuals," and yet who need to be identified in standard transactions." The proposal would make the new Other Entity Identifier (OEID) voluntary and seeks comments on making an OEID system mandatory. FAH members understand that there may be benefits to being able to identify every player in the health care system, but are concerned that this additional information will complicate transactions and could possibly slow down payment of claims. It is not clear what the perceived value of this new information would be to the overall system.

In addition, a number of questions exist that would create increased challenges. They include: (a) Would tracking these transactions require adding another layer of activity to be identified on a claim; (b) What happens if not all entities obtain identifiers; (c) Would a missing identifier slow down claims processing; (d) Would adding an OEID negatively impact cash flow; and (e) Would use of the OEID (or lack of use) require claims to be routed twice? As the value of the OEID is not clear, the FAH urges extreme caution in considering this proposal further. If CMS does move forward to finalize this proposal, the FAH urges a staged approach that prioritizes which entities are most critical to the overall system and should be required to obtain an OEID first.

Expansion of National Provider Identifier (NPI)

The Proposed Rule also seeks comments on additional requirements for covered organization health care providers to require noncovered individual health care providers who prescribe ambulatory prescriptions to: (1) obtain National Provider Identifiers (NPIs) and; (2) to disclose them to any entity that needs NPIs to identify the prescribers in standard transactions.

FAH members are concerned that significant staff time would be required for hospitals and other organization health care providers to track and disclose NPIs for all individuals who may prescribe ambulatory retail prescriptions.

We understand that NPI enumeration is the decision of the provider, so certain providers may choose to obtain only a group NPI, or may elect to not obtain an NPI at all, such as residents in teaching institutions who practice under the direction of an attending physician and do not transmit covered transactions. Although all providers are encouraged to obtain an individual NPI, there is no requirement to do so. Transaction standards 4010A1/5010 NCPDP D.0 for processing retail pharmacy claims requires that Prescriber Segment 411-DB contain the Prescriber ID and Medicare notations for Part D prescriptions and State Medicaid programs instruct the use of the Prescriber NPI number as of May 23, 2008. Although the 5010 standards do not prohibit the use of the group NPI for the prescriber ID, health plans are not expressly prohibited from requesting the individual NPI rather than a group NPI be reported in order to adjudicate claims; therefore, claims with Group NPIs are being rejected by some federally funded prescription drug programs.

Although we understand that retail pharmacy claims may be rejected if prescribers have not obtained an individual NPI or have not revealed it during the prescription-writing process, we feel that it would be overly burdensome for hospitals to assume the responsibility for mandating, tracking and disclosing NPIs to any entity that requires them to process a claim. For example, calls generated from retail pharmacies to Emergency Departments to verify NPIs of prescribing physicians may disrupt the care of patients. The provision of individual NPIs for non-office based providers such as hospitalists and resident physicians would require hospitals to maintain a central location where this information is tracked as well as provide 24 hour staffing to provide these NPIs to retail pharmacies that are open 24 hours per day.

Because of these concerns, the FAH is not convinced that NPIs are needed for these recently identified entities. If CMS decides to finalize this proposal, the FAH suggests that instead of the burden being placed on organization health care providers (e.g. hospitals) to track, maintain, and disclose individual NPIs, all prescribers of ambulatory retail pharmacy prescriptions for Medicare Part D beneficiaries and State Medicaid program recipients should be required to obtain individual NPIs and to disclose them on written prescriptions or electronically transmit them as part of the prescription-writing process, similar to the requirement that a DEA registration number be notated on ambulatory prescriptions for controlled substances.

ICD-10 Implementation Delay

The FAH believes that the CMS proposed delay in the implementation date for ICD-10-CM and ICD-10-PCS, collectively for purposes of this letter "ICD-10," is appropriate and should be very beneficial to the ultimate implementation of ICD-10. The FAH appreciates the Secretary's reconsidering the implementation date in light of the challenges in the transition to the ASC X12 Version 5010 transaction codes. Hospitals have concerns about the convergence of a number of statutory initiatives stretching scarce technical resources. The FAH also agrees with CMS that all segments of the healthcare industry must transition to ICD-10 at the same time because the failure of any one industry segment to successfully implement ICD-10 could potentially affect all other industry segments. Our hospitals were ready to implement 5010, however, we did face challenges when other segments of the industry were not fully able to implement 5010, in particular the lack of readiness of many States posed and continues to pose challenges in timely payments to hospitals. This experience makes FAH hospitals extremely cautious as they assess the readiness for complete transition to ICD-10. Hospitals already are overwhelmed with multiple priorities and activities with large resource and financial impacts. A delay increases a provider's ability to better allocate the resources and dollars to accommodate these priorities. It also permits vendors and developers to fine-tune the systems and to create more robust necessary cross-walks.

FAH members already have invested significant resources in training their staff to meet October 1, 2013 readiness and are well down the path to integrating ICD-10 into their health information technology systems. However, there are many significant issues with ICD-10 implementation yet to be resolved, many of which are outside the scope of hospital control. Therefore, we welcome a delay in implementation. The Proposed Rule recommends a one year delay in the implementation date, moving from October 1, 2013 to October 1, 2014. While some health care stakeholders will support a one-year delay, others will recommend a two-year delay believing a two-year delay offers stronger safeguard against the untenable situation that claims will not be properly processed and paid in a timely manner. All FAH members are extremely concerned about overall system readiness of their trading partners.

Those favoring a one year delay believe that a delay beyond one year would require them to redo work that already has been accomplished because systems inventory would be outdated and need to be completely reassessed. The reassessment process is time-consuming and costly. There also is some concern that hospitals would suffer a loss of momentum as staffs already are well down the path of gearing up for a launch date of October 1, 2013. A one-year delay would allow hospitals to maintain the drum-beat and keep up momentum.

Those who believe a two-year delay is warranted are concerned about significant system-wide complications in moving to ICD-10 the same year many systems would begin to implement Stage 2 of Meaningful Use (MU), depending on when a hospital first attested to Stage 1. In addition, a two-year delay would enable providers to implement and realize the benefits of enabling technology -- such as computer-assisted coding (CAC). A new report by KLAS (a private organization dedicated to improving healthcare technology) finds that about half of healthcare providers are looking to purchase CAC systems within the next couple years. A CAC system can help recoup lost productivity and reimbursements that are expected to come with ICD-10 implementation by creating greater efficiency and productivity. By decreasing the number of coders needed to accommodate the anticipated degradation of productivity associated with ICD-10 implementation, cost avoidance would be realized.

FAH members are concerned about a number of system-wide issues that must be addressed prior to implementation of ICD-10. Whether CMS chooses a one-year delay or a two-year delay, the time gained in any delay must be used wisely to ensure that there is no/minimal disruption to claims processing and other uses of ICD-10 data set. The FAH strongly recommends that CMS establish benchmarks along the way that must be met to guarantee that an implementation delay will achieve its goal of more seamless integration of ICD-10 and a smooth transition that does not disrupt quality patient care. The FAH recommends the following specific benchmarks which must be met in either a one-year or two-year delay. We believe these benchmarks will assure CMS, providers and the overall health care system of the functionality of ICD-10 when it goes live.

The first set of milestones must be addressed at least one-year prior to implementation of ICD-10. That would mean the "one-year prior list of tasks" would need to be completed by October 1, 2013 in order to meet an October 1, 2014 implementation date or October 1, 2014 for an October 1, 2015 implementation date. The next list details the benchmarks that must be met at least six (6) months prior to the implementation date for ICD-10. We are sure that additional unexpected issues will arise as implementation plans progress. Unlike the transition to 5010, ICD-10 implementation and compliance cannot be delayed by a calendar quarter or two. The system must convert all at once. Running parallel systems is extraordinarily expensive and simply not possible.

The following milestones should be established and begin at least one year in advance of the proposed implementation date:

- Specify a trading partner testing schedule similar to what was done for 5010. Testing should include both the processing of claims and remittance advices. Also specify an internal compliance date by which entities must be ready to test. Testing should begin at least one (1) year in advance of the "go live" compliance date and all entities (including

States and small providers and insurers) should be ready no later than three (3) months prior to go live. The 5010 transition schedule (below) should act as the guide.

5010 transition timeline ***For all covered entities***

Effective Date of the regulation: *March 17, 2009*
Level I compliance to begin by:* *December 31, 2010*

*Level II** Compliance by:* *December 31, 2011*

All covered entities have to be fully compliant on: *January 1, 2012*

**Level I compliance means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing." We expect covered entities to be testing throughout calendar year 2011, and to schedule testing as early as possible, to ensure sufficient time for corrective actions and re-testing. **Level II compliance means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."*

To accommodate the two-phase FAH proposed Milestone process, the proposed dates would be as follows:

Proposed ICD-10 Implementation Dates For Milestone Process

ICD-10 Transition Timeline	For All Covered Entities	One-YR Delay	Two-YR Delay
Effective Date of Regulations:	**XX XX, 2012**	**XX XX, 2012**	**XX XX, 2012**
Tasks One-year Prior		**Oct. 1, 2013**	**Oct. 1, 2014**
Tasks Six-months Prior		**March 1, 2013**	**March 1, 2014**

Proposed Milestones to Be Met

- Update all edits, manuals, National and Local Coverage Determinations (NDCs/LCDs), and quality measures to reflect ICD-10.

- Ensure that post-acute reporting tools and reimbursement methods, e.g., Case Mix Groups (CMGs), Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), Resource Utilization Groups (RUGs), and long-term care Minimum Data Set (MDS) are updated and that providers have an ability to assess the changes from both a clinical and payment perspective. In addition, assess impact of ICD-10 when used with DMS-IV for Inpatient Psychiatric Facilities Prospective Payment System (IPF- PPS) and make available any possible complications.

- Ensure the Impairment Group Codes (IGC) for Inpatient Rehabilitation Facilities are assessed and tested in ICD-10 so that medical cases captured by current ICD-9 codes under the so-called IRF “60% Rule” will continue to satisfy that rule when coded in ICD-10.

- Validate the complications and co-morbidities and major complications and co-morbidities (CC/MCC) list, including those codes specific to Psych PPS and the

Medicare Code Editor (MCE), to ensure its accuracy and clearly communicate to the field any major differences between the current listing of MCC/CC compared to the MCC/CC listing under ICD-10. One example of a known difference is the ICD-9 code for esophageal hemorrhage (530.82) which currently is an MCC. The ICD-10 code for this condition is K22.8 and is missing from the MCC list. Whether this represents an omission or removal as an MCC is unknown. These are the types of differences that need to be documented clearly in order to understand the potential impact on the prospective payment systems.

- Monitor and report to the industry quarterly the State Medicaid program ICD-10 readiness status. This is necessary since Medicaid programs were delayed in implementing 5010, and hospitals need to understand how to prepare to deal with their State partners.

- Survey the States to determine which DRG Grouper version they currently are using and make that information known to the field. This survey is necessary because some states, such as Georgia, use DRG grouper versions other than the most current CMS DRG Grouper, and the results of the survey will provide early insight into situations that may require special implementation instructions and/or revenue impact analysis. In addition, other federal payers, such as TRICARE, should be subject to the same monitoring and reporting.

- Make available the provider impact files in order for providers to perform financial analysis and understand the impact of changes. While CMS has stated that ICD-10-CM/PCS will be revenue neutral, certain changes in ICD-10, such as new codes, combination codes, code first instructions, and official coding guidelines may impact DRGs and providers differently. In addition, provider impact files for other groupers such as TRICARE and state Medicaid programs and PPS systems, such as Rehabilitation, Psychiatric, and Skilled Nursing Facilities should also be made available. The impact files should highlight the following:

    - New or removed codes
        - ICD-10 contains new diagnosis codes identifying for myocardial infarction (MI) and guidelines for subsequent and initial MI that will impact MS-DRG assignment. This is also true for reporting medication under dosing, obstetrics, and orthopedics. Additionally, ICD-10-PCS contains an entirely new set of procedure codes that will likely impact MS-DRG assignment.
        - Malignant hypertension, which is a CC in ICD-9, no longer exists in ICD-10.
        - What are other similar changes?

    - Combination codes are codes that are single codes in ICD-10 but were previously two codes in ICD-9. The combination of the codes can result in the elimination of a CC or MCC.
        - This applies in the coding of pressure ulcer and its corresponding stage. In ICD-9, MS-DRG 380 (RW 1.4753) would be assigned and in ICD-10 MS-DRG 594 (RW 0.6981) would be assigned.

- “Code first” instructions are listed in the code book and instruct the coder to sequence diagnoses in a specific manner.
  - In ICD-10, the code first instruction for gangrene with pressure ulcer (L89) instructs the coder to sequence gangrene first, followed by the code for ulcer. This instruction is opposite of what currently occurs in ICD-9 and results in MS-DRGs of 299-301 (RW 0.6646-1.3719) compared to MS-DRG 592-594 (RW 0.69810-1.4753).

- Official coding guidelines are separate from the code book and provide instructions as to how particular codes should be used. For example:
  - When coding anemia of chronic disease with neoplasm (e.g., breast cancer), the ICD-9 guidelines provide instructions to code anemia as the principal diagnoses and the neoplasm as a secondary diagnosis. The ICD-10 guidelines state the opposite. This results in a grouping to MS-DRG 812 (R.W. 0.7957) in ICD-9 and MS-DRG 599 (RW 0.6798) in ICD-10.

- Determine if workers’ compensation programs will process claims using ICD-10 since they are not bound by the new ICD-10 regulations. Do these programs plan to continue with ICD-9? If so, make this information publicly available so that providers can plan accordingly.

- Hold a final review and discussion with the industry on the official ICD-10 Coding Guidelines to point out areas of ambiguity. The Official ICD-10 Coding Guidelines have already been established by the four cooperating parties. The review and discussion with the industry should occur to ensure clarity and consistency in coding. For instance, the ICD-9 guidelines are clearer in noting that the external cause codes are only for the use of those who wish to collect them. In the ICD-10 guidelines, the use of external cause codes is less clear. Given the confusion that occurs with a new classification system, guidelines need to be very specific and clear.

The following milestones should be established and begin at least six months in advance of the proposed implementation date:

- **State Reporting**

  - Ensure State agencies are ready to receive ICD-10 transactions at least six months prior to the proposed implementation date. If states cannot be ready, then suspend State reporting until the state agency can accommodate the new codes. Providers should not be required to submit data in ICD-9 to the States and ICD-10 to the federal payers.

  - Ensure State agencies move toward reporting outpatient procedures in CPT-4 only. Currently eight states require ICD-9 procedure codes for Outpatient State reporting. Due to training, productivity and resource concerns, state reporting agencies should be required to abandon ICD-9 procedure codes and move toward accepting only CPT-4 procedure codes consistent with HIPAA medical code set regulations.

- **Other Registries**: Suspend reporting to other secondary non-CMS data users such as tumor and trauma registries if they are unable to accommodate ICD-10 on the effective date. Providers should not be required to submit data in ICD-9. Reporting should be suspended until the new codes can be accepted.

Other considerations

- With the learning curve for ICD-10-CM, CMS should extend the rebilling requirements for under-coded DRGs from 60 days to 6 months.

- Enforcement and audit activity for ICD-10 should not begin until at least one year after the implementation date.

- CMS should consider contingency plans for interim payments to hospitals once ICD-10 is implemented in the event there are claims processing disruptions.

- CMS should consider limiting the number of retrospective and prepayment audits that are performed during the first year of implementation. Retrospective reviews on claims submitted prior to the ICD-10 implementation date also should be minimized. This is a tremendous change for the industry and providers should not be overburdened by such review activities.

- CMS should not allow any one group, provider or otherwise, to have a different implementation date.

- Where applicable, the implementation of ICD-10 should be made to align more closely with Meaningful Use Requirements, such as implementation of SNOMED.

The FAH welcomes the opportunity to have further discussions on this topic. We appreciate the proposal for a delay in implementation of ICD-10, and we are pleased to answer any questions that might arise from this letter.

Sincerely,