Testimony of Mary H. Stanfill, MBI, RHIA, CCS, CCS-P
on behalf of the
American Health Information Management Association (AHIMA)
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Opening Comments

Chairmen Warren and Blair, Chairman Reynolds, members of the Standard Subcommittee, ladies and gentlemen, good afternoon. Thank you for the opportunity to provide input on the progress and plans toward implementation and use of the ICD-10-CM and ICD-10-PCS classification systems. As you know, AHIMA's health information management (HIM) professionals have been strong advocates for bringing our nation's healthcare information capabilities into the 21st century in order to achieve our goals for robust health information and data integrity.

I am Mary Stanfill, vice president for HIM practice resources at AHIMA. I believe most of you know who AHIMA represents. If you do not; AHIMA is the non-profit, professional association of more than 53,000 HIM professionals. Our member professionals work with healthcare data in provider settings where data is initiated and used for a variety of clinical and administrative healthcare purposes, and in settings where data is received for a variety of reuse purposes, such as payment, public health, quality measurement, clinical research, policymaking, and so on. Because of our unique understanding of healthcare data, we have deep concern for and a commitment to the integrity and completeness of healthcare data, and a deep desire to see efficient and effective implementation and use of the ICD-10-CM/PCS classifications.

Today, I speak to you as an AHIMA employee responsible for supporting both our members and our healthcare industry in the implementation and use of the ICD classifications through development of training and implementation resources. AHIMA represents the largest workforce affected by the code set change, and we provide education and training opportunities for current and future HIM professionals. Additionally, as the only membership association serving the full breadth of HIM professionals, we provide resources across all content aspects of the change, including management, technology, data analysis, reimbursement, research, and policy. We have already begun this effort and will continue at the national and state levels through an established network of affiliated state associations. AHIMA is committed to leading the industry in quality and cost-effective ICD-10-CM/PCS education.

In response to the final rule issued in January 2009, we have expanded our suite of ICD-10-CM/PCS resources and are prepared to meet the challenges of this important upgrade. Today we offer multiple ICD-10-CM/PCS education and training options through asynchronous virtual formats, print and electronic material, online opportunities, and classroom training. For instance, this year alone we:

- Offered at least a dozen print and online publications covering the new code sets
- Trained nearly 400 ICD-10-CM/PCS trainers
- Provided thousands with various levels of training on ICD-10-CM/PCS through meetings, virtual meetings, and webinars
- Began a free electronic ICD-10 newsletter reaching nearly 50,000 subscribers
- And built a robust web site at www.ahima.org/icd10 that compiles ICD-10-CM/PCS resources including free assessment and training tools.

AHIMA also sponsored a multi-stakeholder summit last April, attended by more than 200 provider, payer, vendor, and consultant representatives. We plan to follow it with a second summit this spring to further address implementation issues (we would be happy to include outcomes from NCVHS in that agenda). As I said, AHIMA is committed to leading the industry in ICD-10-CM/PCS education. Indeed we've prepared the resources necessary to accomplish that goal.[i]

After hearing our testimony we hope the committee members will feel more confident knowing it is possible to deliver the industry-wide training needed to implement ICD-10-CM/PCS by October 1, 2013, and that the resources and tools needed to accomplish this are available. The advantages to implementing ICD-10-CM/PCS are achievable. You will also hear though that real barriers do exist, a federal commitment to a solid timeline is absolutely critical, and further delay will increase costs. We are pleased you are holding these hearings and hope you will spotlight the need for all stakeholders to begin implementation planning. We see this transition to ICD-10-CM/PCS as an important step forward for the United States. This is an opportunity for the US to learn and to perfect how we achieve major classification and vocabulary upgrades—a competency required in an interconnected electronic health information system.

Business Process Changes

I will begin by discussing, as requested, business process changes that necessitate training. Focusing on the business processes affected by ICD-10-CM/PCS is necessary in order to fully leverage the use of the new code sets. It is important to manage business process changes so that we actually begin to decrease, not increase, administrative costs. I will explore the most directly affected HIM business processes, starting logically from a patient's early point of contact through the healthcare delivery process.

<u>Patient Registration</u>

The implementation of 5010, a prerequisite to ICD-10-CM/PCS implementation, potentially impacts the business process at one of the earliest points in healthcare delivery–patient registration. It will be important for providers to become familiar with reporting requirements on 5010 transactions to ensure registration data is accurately captured. For example, some health plans assign unique identifiers for the subscriber and the subscriber's family members, and the 5010 transactions facilitate reporting these unique identifier. This means provider organizations will need to determine the impact of patient and subscriber changes to procedures and processes for patient registration. Similarly, the 5010 transaction standard improves data reporting on the present on admission (POA) indicator so providers should review their process for capturing and

reporting POA indicators to ensure compliance with the 5010 standard. These changes are subtle, with minimal training requirements and significant opportunity to improve the workflow and overall consistency in data collection during the registration process.

The patient registration process is also influenced by ICD codes. At the point when a healthcare service is scheduled, or a patient registers for an outpatient test, for example, the provider verifies coverage of the service by the patient's health plan. Coverage determination is based on medical necessity or other payment policies, many of which are determined by ICD codes. The staff that carries out this process will require training on ICD-10-CM and any software applications used in this process must be converted. However, increased detail in the ICD-10-CM codes will make it easier to verify coverage.

Documentation and Data Capture

There are differences in terminology and the level of specificity detailed in ICD-10-CM/PCS from ICD-9-CM. Thus, to fully benefit from the greater specificity in the new code sets, we anticipate providers must be made aware of details that can be encoded so they can record them.

This phenomenon is nothing new; it happens today with annual code updates. The codes follow scientific discovery and the advancement of knowledge and documentation should reflect current standards of care. For example, the medical terminology for congestive heart failure changed in recent years to specify diastolic and systolic types of heart failure, and the ICD-9-CM codes were changed to accommodate that. The new ICD-9-CM codes for systolic and diastolic heart failure could not be used, however, unless physicians began to document the type of heart failure. As more physicians begin to do so, the unspecified CHF code is used less often and the granularity in the data is thus increased. This provides benefits both for the healthcare providers and those working with the secondary information—for example, in research.

Similarly, ICD-10-CM provides the opportunity to capture diagnoses in greater detail, but the more specific codes can only be used if physicians are aware of, and document, the elements that can be captured to fully reflect the patient's condition and treatment provided. The 10th version of ICD was developed with substantial input from physician organizations specifically to capture the clinical details of modern medicine. Today, relevant detail is often lost in ICD-9-CM that ICD-10-CM/PCS is able to capture with no additional documentation. For example, laterality has been added to ICD-10-CM, and clinical documentation should already reflect left or right side. Obstetrical encounters are another example as ICD-10-CM classifies obstetrical conditions according to the trimester, and providers nearly always document what week the patient is in (which is easily converted to a trimester). However, we know there is opportunity for improvement in the specificity of clinical documentation. Clinical documentation improvement programs, an existing and ongoing business process in many provider organizations, will need to focus on the priorities for documentation needed to fully utilize the ICD-10-CM/PCS code sets. This will entail training for clinical documentation improvement specialists and the clinicians responsible for clinical documentation.

We anticipate ICD-10-PCS will have a stronger impact on documentation than ICD-10-CM. This is because ICD-10-CM is similar to ICD-9-CM, whereas ICD-10-PCS is differently structured in comparison to ICD-9-CM procedure classification codes. The diagnoses in clinical

documentation today closely match the terminology used in ICD-10-CM, whereas the terminology used in ICD-10-PCS is very different.

It is not too early for providers to review their documentation forms and templates to facilitate use of the new code sets. They also can begin to conduct provider training to create awareness of the specificity allowed in ICD-10-CM and the terminology used in ICD-10-PCS. This carries implication for EHR system vendors as well, as there is an opportunity to improve documentation capture techniques to leverage the data specificity available in the new code sets.

While non-specific codes are still available for use when documentation doesn't support a higher level of specificity, documentation improvement tailored to the ICD-10-CM/PCS systems is important to achieve higher data quality. This is necessary as more detailed data is being demanded by a number of initiatives, including for example quality measurement and value-based purchasing. AHIMA believes that documentation process improvements, prompted by the code set change, will ultimately help achieve the goal to improve the quality of healthcare data.

Code Assignment Process

The code assignment process itself does not have to change drastically to accommodate the new code sets, although electronic health records provide opportunities for automating the coding work flow. The significant impact here is the need for the current coding workforce to become proficient in consistently applying ICD-10-CM and ICD-10-PCS codes. This training impact is different in different healthcare settings because not everyone will use ICD-10-PCS.

According to the final rule implementing ICD-10-CM/PCS[ii], these new code sets will replace the current uses for ICD-9-CM diagnosis and procedure codes. The use of CPT® codes is not affected. ICD-10-PCS will be used to report procedures reported with ICD-9-CM Volume III procedure codes (that is, hospital inpatient procedures). ICD-10-PCS codes will not be required for any provider setting except acute care hospitals.

Coding professionals, who currently assign ICD-9-CM diagnosis codes and perhaps CPT® procedure codes, must learn to report ICD-10-CM diagnosis codes and continue to report CPT® procedure codes where applicable. This includes, for example, hospital outpatient coders and coders who work in physician practices, outpatient clinics, long-term care facilities, home care, outpatient rehab centers, and so forth. It is significant these coders are not required to use ICD-10-PCS because learning ICD-10-PCS is more time-intensive. ICD-10-CM is very similar to ICD-9-CM, and those who are proficient in ICD-9-CM require only a couple of days of training to make the transition. AHIMA has extensively investigated this and recommends coders who must learn ICD-10-CM only need a total of 12 hours training and 4 hours practicing coding typical encounters. This breaks down as follows:

- Six hours learning the fundamentals of ICD-10-CM to understand the code structure, coding conventions, related coding guidelines, and how ICD-10-CM is different from ICD-9-CM
- Six hours in more intensive training applying the ICD-10-CM coding conventions and guidelines

- Four hours practicing applying ICD-10-CM codes to typical encounters to gain proficiency in code assignment

In contrast, hospital inpatient coders must become proficient in ICD-10-PCS and ICD-10-CM. ICD-10-PCS requires more time to master as it is a radical, but necessary, departure from any procedural coding system the US has previously employed. In addition, the organization and structure of ICD-10-PCS requires the coder understand clinical distinctions in procedural approaches and anatomy in order to select the correct code. For example, in ICD-10-PCS, an incision is an approach, not in itself a procedure. To assign a code for "incision and drainage" the coder considers what the incision is for (in this case, drainage), so the code assigned is drainage and the incision—the way you accomplished the drainage—does not require a separate code. Another example is the colonoscopy, which is classified as an inspection in ICD-10-PCS. Medical coders learning ICD-10-PCS require orientation to the new structure and the terms consistently applied throughout the classification. While it takes time to learn, ICD-10-PCS is easy to use because of its logical structure and standardized definitions and terminology. Software applications leverage the structure and definitions to increase efficiency and accuracy of the code selection process.

Hospital inpatient coders, who must master both ICD-10-CM and ICD-10-PCS, will need to spend 40 hours training and 10 hours practicing coding inpatient encounters. This breaks down as follows:

- 16 hours in the fundamentals of ICD-10-CM and ICD-10-PCS to understand the code structure, coding conventions, and related coding guidelines for each classification system
- 24 hours in more intensive training applying the coding conventions and guidelines for both systems
- 10 hours practicing applying both codes sets to hospital inpatient encounters to gain proficiency in code assignment

AHIMA has developed a complete training strategy for hospital inpatient coders, as well as coders in other healthcare settings, which explores how a provider organization might support this amount of training while balancing its workload and continuing to meet account receivable goals[iii]. I will describe this in more detail when we discuss training. In terms of the business process impact, certainly the amount of time away from job duties for training has an impact on productivity and workflow, the degree of which is relative to the healthcare setting. In addition, the amount of training described above is focused on learning to use the new code sets. AHIMA has recognized that some coding professionals may need to refresh or expand their knowledge in the biomedical sciences (anatomy, physiology, pathophysiology, pharmacology, and medical terminology), particularly those who will use ICD-10-PCS. As noted previously, the medical coder must understand clinical distinctions in procedural approaches and anatomy in order to select the correct ICD-10-PCS code. For example, they must be able to understand why an incision and drainage procedure is classified under drainage, not incision, and recall that a colonoscopy is an inspection.

The number of hours for retraining on the biomedical sciences depends on the current competence and educational background of each coder. Thus it will be important to assess the

knowledge base of the current coding staff and develop tailored training plans accordingly. This allows providers to be as efficient as possible in the use of training resources. Providers who strengthen their coding staff's foundational biomedical knowledge, in preparation for training on the code sets, will find the coding staff is more successful in learning the ICD-10-PCS system, and will avoid additional costs for retraining and lost productivity.

Naturally, workflow is impacted by training, and a strategy distributing training across all three years is needed. In addition, once the ICD-10-CM/PCS systems are implemented, impact on the coding workflow is predicated upon sufficiency of the documentation to support the greater specificity available in the code sets. As noted previously, AHIMA recommends that provider organizations anticipate and improve documentation capture prior to ICD-10-CM/PCS implementation to avoid having to rely too heavily on unspecified codes or hold up claims trying to address documentation deficiencies retrospectively. Lastly, workflow is also impacted by coder accuracy and productivity. Both of these are expected to decline for a short time while coders are learning the new code sets. The length of this transition period, and the impact on data quality, will be less for ICD-10-CM than for ICD-10-PCS due to the similarities to ICD-9-CM. And adequate training and evaluation of competence can shorten the learning curve. Ultimately, it is expected that coding accuracy and productivity will rise to a level better than today due to the improved logic and standardized definitions in ICD-10-PCS, the more accurate clinical terms in ICD-10-CM, and the more specific code descriptions in both systems. The additional detail and specificity in these code sets assists in advancing the use of technology tools and computer-assisted code selection, which will further improve coding consistency and productivity.

Business processes employed in some healthcare settings to communicate coding information internally must be reviewed and modified before October 1, 2013. For example, physician practices employing a paper charge ticket or "superbill" with ICD codes printed on the form need to update these forms. Similarly, electronic charge capture systems must be updated. This is not an onerous task. Superbills utilizing ICD-10-CM codes can still be customized to reflect the most common conditions treated by the practice. AHIMA re-coded primary care superbills and found it can be easily done in less than a day (samples are available at www.ahima.org/icd10/).

Considering the longer term, AHIMA expects that translation of clinical data into classification codes for administrative use will improve as a result of this transition to ICD-10-CM/PCS. We expect advances in natural language processing to continue to mature and computer-assisted coding software to begin transforming traditional work processes to improve efficiency and reduce costs. The improved structure, logic, and specificity of ICD-10-CM/PCS will result in greater use of knowledge management tools to support the code reporting and claims processing functions. This in turn leads to increased productivity, fewer staff required for manual processing (by both providers and health plans), and relief of the existing workforce shortages.

Billing/Claims Submission

The workflow for billing, or claims submission, processes is affected by upstream changes in the coding process. Delays upstream could delay billing. In addition, billing and business office staff in provider organizations must be familiar with the new code sets and need to re-learn data level issues affecting claims processing so claim rejections do not increase. New data edits are

required for both 5010 and the ICD-10-CM/PCS code sets. These adjustments, however, ultimately benefit both provider organizations and health plans as more detailed and accurate ICD-10-CM/PCS codes result in fewer claims rejections and requests for additional information to accompany claims—a current problem in the process that employs ICD-9-CM today.

In some provider organizations, coding and billing are done by the same staff, in which case the training needs described above for the code assignment process would apply. In organizations where billing staff do not assign ICD codes, the training needs are less than for medical coders. Training should focus on the fundamental differences between ICD-9-CM and ICD-10-CM/PCS.

Data Use and Re-use

Users of healthcare data captured in ICD, throughout the healthcare industry, will be affected by the transition to the ICD-10-CM/PCS code sets. Data trends and comparability for decision making, clinical research, epidemiology, and public health purposes will require careful analysis. An understanding of the specific nuances of how ICD-9-CM data differs from ICD-10-CM/PCS data will be required to avoid misinterpretation of data trends. For example the definition of an acute myocardial infarction (AMI) in each system is different. In ICD-9-CM an AMI is an MI that occurred in the past eight weeks, but in ICD-10-CM an AMI is defined as an MI that occurred in the past four weeks. This distinction is not in the code title, but in the definition of the code itself. As a result of this change, the number of AMIs reported with ICD-10-CM will no doubt be significantly lower than the number of AMIs reported with ICD-9-CM. Someone who is un aware of the change in the code definition might misinterpret this data trend as an indicator that the AMI rate has decreased significantly.

The transition to ICD-10-CM/PCS also affects clinical decision support systems and applications for data reporting that incorporate ICD codes. These applications require retooling of the logic based on ICD-9-CM. This necessitates training for those involved in the retooling effort and likely the use of maps and mapping tools. Similarly, disease management programs using ICD codes to identify patients must be re-tooled.

These adjustments, however, are absolutely necessary for our healthcare data to reflect modern medicine. The primary reason there are so many differences between the code sets is that ICD-9-CM is obsolete, while ICD-10-CM/PCS reflect modern clinical medicine. The move to ICD-10-CM/PCS is critical to improve the quality of the data. In many instances the data captured in ICD-9-CM is clinically wrong, so the change is needed and will be worthwhile for those who use and re-use the data.

Other Business Process Impacts

AHIMA has heard concerns from many in the healthcare industry that non-HIPAA-covered entities are not required to transition to ICD-10-CM/PCS and thus may not do so. This would be costly and burdensome for providers if some of these entities choose not to make the transition. To ensure successful implementation in the US, it is essential for CMS to work with these entities to help them understand the value and importance of transitioning to the new code sets. CMS should also keep the industry informed as to the success of CMS' efforts in this area.

It is essential that all covered entities are ready to comply for dates of service on October 1, 2013. Consequences of inadequate preparation include increased coding backlogs, claims rejections and denials, compliance risks, implementation costs, and reliance on faulty data for decision-making. For example, a steady stream of transactions between provider organizations and clearinghouses and health plans is important for stability in the healthcare reimbursement process.

Any delay in implementation would have a devastating effect on the healthcare industry, as it would substantially increase the cost and amount of work required to make the transition. To offset this chain of events, it is important to start early to prepare, educate, and test. Proper planning and preparation can mitigate potential problems and reduce implementation costs.

ICD-10-CM/PCS Training

As evident in the previous discussion on business process changes, the workforce requiring training in the ICD-10-CM/PCS code sets across the healthcare industry is wide and varied. It starts with the implementation team. Whoever is leading the transition planning and implementation, and the decision-makers they work with, will require training in ICD-10-CM/PCS. Below is a description of the workforce the implementation teams must ensure is trained in all sectors of the healthcare industry.

The workforce trained in provider organizations (inpatient, ambulatory, and other settings) includes those who:

- Function off information based on ICD codes
- Generate the information used to assign ICD codes
- Assign ICD codes for patient services
- Analyze and interpret coded data

The workforce trained in clearinghouses or health plans includes those who:

- Process claims
- Respond to provider enquiries
- Analyze and interpret claims data
- Update contracts and contract templates
- Develop coverage policies based on ICD codes

The workforce trained in vendor organizations includes those who:

- Determine priorities for product updates
- Design and write computer code

The workforce trained in academic programs (with programs related to medical coding) includes those who:

- Write curricula that include medical coding
- Teach courses with any medical coding content
- Make decisions about medical coding curriculum changes and updates

The workforce trained in public health (or clinical research, or anywhere secondary data is used) includes those who:

- Analyze and interpret ICD coded data
- Function off the information based on ICD codes

Training such a vast and varied workforce is daunting, but AHIMA believes it can (and must) be accomplished, and offers the following six guiding principles to do so effectively and efficiently.

1. Customize training to the role

Some individual roles require more training than others, depending on how they use or interact with ICD. Organizations should identify who needs to know what and develop a role-based training plan reflecting that. For example, in a provider organization, physicians typically do not need to be proficient in assigning ICD codes, but they must be aware of the new code set and documentation elements they want to capture to improve the usability of their clinical data. In contrast, hospital inpatient coders must become proficient in assigning ICD-10-CM codes and ICD-10-PCS codes, while coders in other settings must be skilled in assigning ICD-10-CM codes, but do not necessarily need to learn ICD-10-PCS. Training provided to a physician, an inpatient coder, and coders in other settings can be designed differently to specifically address what each role needs to know. This approach allows the learner to focus on what he or she is interested in learning and will apply, while avoiding training fatigue. It also helps the organization focus training resources and minimize waste.

2. Assess competence and tailor training to the individual

Training plans can be further tailored to the individual by assessing individual competence. For example, an organization might deploy awareness training system-wide by utilizing a simple pre-survey tool that meets their objectives and potentially saves hours of lost productivity in training time for those who "test-out."

More sophisticated assessment tools are available. One example are assessments to identify training needs in biomedical knowledge required to apply ICD-10-CM and/or ICD-10-PCS codes. AHIMA recommends that provider organizations present such assessments to their coding staff to determine where to target anatomy and physiology refresher courses. Medical coders have various educational backgrounds, experiences, and specialties. Some have recent and relevant anatomy and physiology knowledge and others do not. Some have coded complex and wide-ranging scenarios while others don't. The more training meets the individual needs across this spectrum, the more effective and efficient it is likely to be. Assessing individual competence allows the organization to further focus and prioritize training resources and provide training where it is most needed.

3. Provide training at the right time

Provide the right training at the right time to allow sufficient time for learning and to avoid retraining. Training on any particular issue should be deployed close to the effective date for the individual. Acquiring knowledge months, or years, before it is applied is not efficient, as this

inevitably results in varying amounts of follow-up and retraining that consumes additional training resources.

For example, now is the time to measure coding professionals' baseline knowledge of anatomy, physiology, pharmacology, and medical terminology so education can be targeted where competency is required. Measuring the coders' baseline knowledge now will shorten the learning curve, improve coding accuracy and productivity, and accelerate the realization of benefits. Additionally, in 2009 and 2010, coding professionals should familiarize themselves with the basic features of ICD-10-CM and ICD-10-PCS and how these code sets differ from ICD-9-CM. It is too early to start intensive, in-depth ICD-10-CM/PCS training for coding professionals. The most effective time for in-depth training of coding professionals to ensure proficiency in assigning ICD-10-CM/PCS codes is six to nine months before the implementation date.

4. Leverage the full implementation time span

AHIMA is advising healthcare entities to develop training plans that use the full implementation timeframe. Spreading out the training across time is a much more efficient use of resources; it helps to contain productivity loss to a degree more readily absorbed and thus minimizes the impact on workflow. For example coding staff might be in training one day a month for five months, without impeding the department's workflow. However, if the coding staff is in training for five days in one week, workflow is impeded and a backlog might ensue that takes many weeks to correct. In addition, graduated training is easier for the learner. In general, training on ICD-10-CM/PCS can be spread over time:

- Start with building awareness to understand the impact of the code set change and the differences between the code sets.
- Next, build pre-requisite skills where needed, for example, in the biomedical sciences
- Proceed to foundational concepts on the structure and organization of the code sets and their corresponding guidelines for coding and reporting
- Finally, move on to role-based application "just in time"

5. Employ varied training methodologies

Learning methodologies should vary depending on the learning objectives. Some training will involve imparting knowledge, explaining information in a straightforward one-way communication. At other times you are attempting to impart expertise, expecting the learner to apply or interpret the information. The training methodology should be tailored to what you need to accomplish with the learner. Methodologies should also be varied to accommodate multiple adult learning styles. Currently available training methods for ICD-10-CM/PCS training are listed here.

> Distance education: Online training is typically asynchronous and can be deployed as a fully independent study (with little or no interaction with a facilitator or other students) or it can be instructor-led (with regular interaction with the instructor and other learners). The advantages to distance education are that it is available any place with computer and Internet access, scheduling is very flexible, and there are no travel costs.

Webinars, audio seminars: These are short seminars broadcast over the Internet or a teleconference line. They may be scheduled at a specific date and time, or recorded and archived for purchase. Webinars and seminars typically include resource materials and may or may not include question and answer periods. The advantages to webinars are that they are easily broadcast to a large audience, may be available in archived format or available for download to mobile devices, and involve no travel costs.

Virtual meetings: These are educational meetings broadcast through the Internet. They typically include both audio and visuals, and a process to submit questions to the speaker(s). Virtual meetings include the opportunity to interact to some degree with the expert speaker, communication is fuller, and travel costs are either eliminated or minimal (if the virtual meeting is broadcast to a regional location).

Publications: This includes hard copy, bound books, journals or other periodicals, and electronic materials. Multiple academic texts are available, in addition to professional books. Books may include exercises, come with or without answer keys, and include CDs with assessment questions to test learning. Electronic newsletters may also include exercises to test knowledge and links to additional Internet resources. The advantages to publications are that they are sharable, reusable, and tend to cover a topic in great depth.

In-person Training: Sometimes referred to as face-to-face training, this involves traveling to a place and gathering in a designated location at a designated time to listen and interact with expert speakers. Meetings vary in size and instructional design. They can employ a workshop format with application and group learning, or they can be more predicated on a subject matter's expertise. The advantages include the opportunity for full communication and interaction with expert speakers, access to renowned subject matter experts, group learning, and networking with other attendees.

A healthcare entity will likely employ all these mechanisms to varying degrees in training individuals affected by the transition to ICD-10-CM/PCS. To appeal to various learning styles, and because budget availability and access to certified trainers and training vary, AHIMA has developed training in various shapes and sizes. Healthcare entities can readily obtain training tools through various delivery methods, at varying price points, and in optional packages.

6. Leverage Training Across the Organization

Efficiencies can be gained by leveraging learning within the organization wherever possible. AHIMA recommends employing a "train the trainer" model. A lead person, designated as the trainer, attends in-person training, then returns to the organization to impart what they learned to other staff. "Train the trainer" can be implemented interdepartmentally and also across roles and departments.

Training this diverse workforce in ICD-10-CM/PCS can be done efficiently and effectively with proper planning and preparation, following these six guiding principles. To illustrate how these guiding principles might be employed, we developed two case examples. The case examples show the type of training to be provided and the amount of time needed to train the coders in a

hospital and in a multispecialty physician practice. We chose to focus on the coder roles in two healthcare provider settings because coding professionals need the greatest amount of training in any individual role.

1. Hospital Case Example

This case example reflects ICD-10-CM/PCS training for the coding department in a hospital of moderate size (under 200 beds) with 10 full-time coding professionals, including one internal reviewer, seven inpatient coders, and two outpatient coders. The plan, detailed in Table 1, reflects customized training for the coders beginning in 2010 through 2013.

Table 1. Hospital ICD-10-CM/PCS Training Plan for Coders

Budget Year	Training	# of ppl to train	# of hrs in training	Total training time
2010	Introductory training/awareness webinar	10	1	10
2010	Online ICD-10-CM A&P assessment	10	3	30
2010	Online ICD-10-PCS A&P assessment	8	3	24
2011	Online pathophysiology in depth training	1	48	48
2011	Online A&P refresher course	6	4	24
2011	Academy to train the trainer	1	50	50
2011	Trainer preparing to give training	1	40	40
2012	Training on ICD-10-CM/PCS (held on-site)	8	16	128
2012	Training on ICD-10-CM (held on-site)	3	6	18
2013	Training on ICD-10-CM/PCS (held on-site)	8	24	192
2013	Training on ICD-10-CM (held on-site)	3	6	18
2013	Practice inpatient coding (2 hours per week for 5 weeks)	8	10	80
2013	Practice outpatient coding (1 hour per week for 4 weeks)	3	4	12

The ICD-10-CM/PCS training plan begins with all 10 staff members in a coding department attending an introductory training session to build awareness of the code set transition. All coding staff subsequently complete assessments in the year 2010 to identify any weaknesses in the biomedical sciences. As a result of the assessments, we presumed, for example's sake, that one coder will take an in-depth pathophysiology course and six coders will complete a refresher course on anatomy and physiology (A&P). This plan then includes one person attending a train-the-trainer program and subsequently preparing to train the rest of the coding staff. The assumptions made to build this case example include:

- The one internal reviewer and seven inpatient coders must learn both ICD-10-CM and ICD-10-PCS, but the two outpatient coders must learn only ICD-10-CM
- 40 hours of training and 10 hours of practice coding are needed to learn both ICD-10-CM and ICD-10-PCS

- 12 hours of training and 4 hours of practice coding are needed to learn ICD-10-CM only
- The hospital intends to pay employees for time spent in ICD-10-CM/PCS training (rather than considering it a professional continuing education activity the employee is responsible for) so training is built into the work day
- Based on the A&P assessments, one coder needs in-depth training in pathophysiology, and six coders need an A&P refresher course

Note that the plan is tailored to the individual coders, by employing online assessments. Also, the training is spread out over four years so the coders receive the right training at the right time and the full implementation time span is leveraged. Training methodologies are varied, employing webinars, distance education, and in person training. Lastly, the train-the-trainer model is employed.

This case example illustrates how training for the coding department might be spread out across all four years. There is a significant amount of training in 2011 because the hospital is investing in training on the biomedical sciences and developing a trainer who will train the rest of the coding staff on ICD-10-CM/PCS. This preparation helps control the training time in 2012 and 2013. The year 2013 is when the greatest amount of training is needed, because this is when all coding staff receives in-depth training and practice using the new code sets to ensure proficiency in assigning ICD-10-CM/PCS codes by the October 1 implementation date.

2. Physician Practice Case Example

This second example is a multispecialty physician practice with approximately 40 physicians. The coding staff includes five full-time coders and a coding manager who conducts internal coding reviews, and will be the ICD-10-CM trainer. The training plan for the coding department, reflected in Table 2, is similar in concept to the hospital coder training plan in the first example. We applied the same recommendations for the amount and timing of training, concentrating on ICD-10-CM training only. Assumptions applied to this second case example include the following:

- The coders and coding manager must learn to be proficient in ICD-10-CM (but do not need to learn ICD-10-PCS)
- 12 hours of training and an additional 4 hours practice coding are needed to learn ICD-10-CM
- The Practice intends to pay employees for time spent in ICD-10-CM training (rather than considering it a professional continuing education activity that the employee is responsible for) so training time is built into the work day.
- Based on the A&P assessments, two coders need a refresher course on A&P

Table 2. Physician Practice ICD-10-CM Training Plan for Coders

Budget Year	Training	# of ppl to train	# of hours in training	Total training time
2010	Introductory training/awareness webinar	6	1	6
2010	Online ICD-10-CM A&P assessment	6	3	18
2011	Online A&P refresher course	2	4	8
2011	Academy to train the trainer	1	24	24
2011	Trainer preparing to give training	1	20	20
2012	Training on ICD-10-CM (conducted on-site)	6	6	36
2013	Training on ICD-10-CM (conducted on-site)	6	6	36
2013	Practice coding (1 hour per week for 4 weeks)	6	4	24

By employing A&P assessments, his physician practice example is also tailored to the individual coders, and the training is similarly spread out over four years to leverage the full implementation time span. In addition, as with the first example, training methodologies are varied and the practice employs a train-the-trainer model, so all six guiding principles are again employed. Note that the most training-intensive years are again 2011 and 2013 when the practice is preparing to train and then deliver the bulk of the training, two key years for ICD-10-CM/PCS implementation.

These two case examples address only the coding department in each organization. As we've discussed today there are many others who must be trained, but you can see from these examples how a training plan is customized and will vary, even for similar roles, for each organization.

Both of these examples presume that the healthcare provider intends to pay employees for time spent in ICD-10-CM/PCS training. This may not hold true universally, some employers may consider this an employee's professional responsibility, a professional continuing education activity the employee is responsible for. There is a precedent for this. Many employers, for example, provide tuition reimbursement to cover the cost of training, but expect the employee to do the learning on his or her own time. In addition, credentialed coding professionals are doing some of this continuing education now, to meet CEU requirements for credential maintenance. Some of the ICD-10-CM/PCS training will supplant that.

Another factor influencing training is that many healthcare delivery systems have a learning management system and utilize it as part of their coding review and compliance program. When errors are identified in a particular area, mandatory coursework is assigned. ICD-10-CM/PCS training will supplant this as well. This is not reflected in the two case examples here. These case examples merely reflect the training for coders specific to ICD-10-CM/PCS.

The training plan outlined in these case examples could be used as a starting point to create a budget plan for the coding department. In doing that, you would have to consider how to backfill staff while they are in training, perhaps with overtime or contract coders. Though many of AHIMA's constituents have indicated they do not expect to pay overtime or contract coders. Instead they will spread out the training sufficiently to absorb any workflow impact.

I have a few additional thoughts regarding training I want to relay. An important consideration in devising training plans is that a hands-on, real-world environment is needed to make training effective. Healthcare entities require an environment where they can conduct side-by-side testing so the practice can be as close to live as possible. In the final "go-live" stages, at least, training should reflect the actual work an individual will perform as closely as possible. For coding professionals this might mean coding patient encounters in ICD-10-CM/PCS, which are similar to the type of encounters they typically code on the job, using ICD-10-CM/PCS versions of the encoder (or other coding tools) they regularly employ. ICD-10-CM and ICD-10-PCS code books are already available, and those who use an encoder application rely on their encoder vendors to supply an ICD-10-CM/PCS version during the 12 month period preceding the implementation date. To help meet this need, use of an ICD-10-CM/PCS encoder via the AHIMA Virtual Laboratory[iv] will soon be incorporated in AHIMA's ICD-10-CM and ICD-10-PCS online courses.

I further want to note that all the training methods discussed here are currently available for training in ICD-10-CM/PCS. AHIMA is confident that the methods to train thousands of individuals in ICD-10-CM/PCS exist today. AHIMA began training trainers in ICD-10-CM/PCS in 2009; we will do more in 2010, and we could ramp up to do even more if needed. The only limiting factor is resources (that is, availability of funding for the training).

Cynicism and the economy have slowed the speed of adoption of ICD-10-CM/PCS training resources. AHIMA's constituents report that upper management is slow to believe that transition is imminent based on previous delays. Available budget is another issue, based on other priorities such as RACs and the impact of a down economy. Organizational planning resources are needed–a case needs to be made for them, and coordination between covered entities is key.

Web-based Training

I have one last issue to comment on before I close. The subcommittee asked me to respond on whether or not training programs can be deployed effectively via the Web to maximize reach and reduce costs. I feel strongly that training programs absolutely can be deployed effectively through the Web. AHIMA is already employing Web-based training in our ICD-10 Academies, which currently include online training followed by an in-person meeting. The in-person portion we currently deliver is the most interactive. This portion of the training teaches attendees to be trainers, and the time is spent in building expertise and confidence so they are fully equipped to train others. We could absolutely modify our online training to include the additional in-person portions, so the entire training could be done online. This entails adjusting the online instructional design so it is instructor-led, rather than independent study, and adding facilitators to respond to questions and provide feedback.

Entire graduate degrees are available online, from well-known academic programs. If a person can earn a master's degree online, surely it is possible to offer effective ICD-10-CM/PCS training online. Online course tools provide mechanisms to pose questions, hold discussions, chat, and interact with fellow students and the instructor. In addition, learners can set their own schedules and move at their own pace.

Web-based training has multiple advantages for training this workforce. It helps reduce training costs overall by limiting staff travel and reducing the number of staff away from their desks for training at the same time. It gives the learner multiple opportunities to review the same material. Skill level testing and the ability to tailor the training to the experience and proficiency of various coders are also advantages. The flexibility for the learner to work on the course any time, anywhere with Internet access is increasingly important as more providers have remote coding staff. Web-based training allows staff to work on gaining expertise, a few hours at a time, at their own pace, avoiding a burden on the facility of staff being in training all at one time.

Concluding Comments:

AHIMA knows this transition to ICD-10-CM/PCS is no small undertaking and there are important changes competing for attention in healthcare delivery, including adoption and use of electronic health records (EHRs). A successful transition requires significant energy and resources as multiple business processes and multiple individuals are impacted. A training element is needed for providers, health plans, clearinghouses, healthcare vendors, and academic institutions with coding related programs. This training requires thoughtful planning, as the best way to be efficient is to use the full implementation timeframe and devise customized training plans. In spite of these challenges, we absolutely must update the code set standard.

To reach the vision of an interconnected electronic health information system in the US, we have to be able to employ standards, and current clinical terminology and classification system standards are among the most important factors to get there. We have to learn how to employ classification standards consistently and we must maintain them so they reflect current medicine. We have failed in that regard in the last several years and we must rectify that now. Given other current federal healthcare initiatives, such as healthcare reform and EHR implementation, this is a critical time for taking advantage of contemporary code sets designed for electronic environments. The goals of these initiatives, including improved healthcare quality and administrative efficiencies, cannot possibly be achieved if the data output from our healthcare system is in the form of an obsolete, inadequate classification. Clinical terminologies including SNOMED CT® paired with ICD-10-CM and ICD-10-PCS create opportunities for improved data management and health information exchange.

Delaying implementation of ICD-10-CM/PCS is not an option. It only grows more expensive to wait. This transition is similar to Y2K where all changes are predicated upon the implementation date. Delay, ostensibly to give people more time to comply, is not helpful. It creates extensive rework, requiring the implementer to go back and update systems with a new date, and wastes resources, since already deployed training would have to be re-done. AHIMA recommends CMS publicly and regularly reaffirms a solid commitment to the 2013 compliance date, with absolutely no plans for a delay or extension.

The tools and resources to make the transition to ICD-10-CM/PCS currently exist, but cynicism and the economy have slowed the speed of adoption of these resources. Healthcare entities need confidence that the implementation date is solid so they can move forward without fear their resources are wasted. We need federal commitment to a solid timeline—any wavering on the implementation date and the industry will be paralyzed

AHIMA and its members are pleased the NCVHS is taking a concerted interest in issues related to the transition to ICD-10-CM/PCS, and we are ready to work with the subcommittee and the full committee to help our industry move forward. Thank you again for the opportunity to contribute to your discussion here today. I will be happy to answer any questions.

Thank you.

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[i] Information on AHIMA training resources is available at: http://www.ahima.org/icd10/education-training.html

[ii] Final rule on ICD-10-CM/PCS: http://www.access.gpo.gov/su_docs/fedreg/a090116c.html

[iii] AHIMA's ICD-10 role-based training and implementation model is located at: http://www.ahima.org/icd10/role-based-model.html

[iv] AHIMA has developed a Virtual Laboratory that provides educators and students in campus-based and distance learning colleges and universities with single site, virtual access to a full array of HIM technologies. For more information visit: http://campus.ahima.org/vlab/