

*Via online submission*

October 21, 2008

The Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attn: CMS-0013-P; Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Re: HIPAA Administrative Simplification: Modification to Medical Data Coding Set Standards to Adopt ICD-10-CM and ICD-10-PCS; Proposed Rule**

Dear Sir or Madam:

The American Occupational Therapy Association (AOTA) represents over 38,000 occupational therapy professionals, many of whom currently utilize the ICD-9-CM coding system in their health care practices treating beneficiaries under Medicare Parts A and B. We appreciate the opportunity to comment on the rule addressing HIPAA Administrative Simplification under the Modification to Medical Data Coding Set Standards to Adopt ICD-10-CM and ICD-10-PCS Proposal (hereinafter, "ICD-10 Proposed Rule"), as published in the Federal Register on August 22, 2008 at 73 Fed. Reg. 49796. AOTA presents the following comments on the ICD-10 Proposed Rule.

AOTA understands the need for the new ICD-10 coding system, which would account for many problematic aspects of ICD-9, including but not limited to: lack of detail in codes, lack of space for new codes, lack of laterality in codes, generic terms to describe body part, and incompatibility with the coding systems of other countries. However, AOTA supports the comments provided by the American Medical Association and provides additional comments related to the specific concerns of occupational therapy professionals.

**Delay Implementation Timeline for ICD-10**

Under the ICD-10 Proposed Rule, CMS would require that all affected stakeholders be in compliance with the new coding system by October 1, 2011. This is an unrealistic time frame for practitioners such as occupational therapists (OTs) to come into compliance with a new coding system because such a large scale change in coding requires an equally significant transition of therapy practice billing systems. Occupational therapists provide therapy services in a large variety of Medicare settings including, but not limited to: private practice, outpatient clinics, rehabilitation agencies, hospitals, skilled nursing facilities, inpatient rehabilitation facilities, home health care, and inpatient psychiatric hospitals. Some occupational therapists work in solo or very small private practices and can not afford the financial burden required to transition the practice billing system by October 1, 2011. Larger facilities may have the funding sources readily available to come into compliance more quickly. AOTA urges CMS to reconsider the time frame for full implementation of the ICD-10 system and to phase in different

Medicare settings based on their readiness to undertake the burdens of this coding transition. Regardless of implementation date, education of a great number of stakeholders, including therapy professionals, must be undertaken concurrently with the implementation of this new system.

### **ICD-10 Does Not Remedy the Lack of Functional Diagnoses in ICD-9**

Although AOTA appreciates that the ICD-10 system will incorporate much greater specificity and clinical information in the new codes than the ICD-9 system, AOTA remains concerned that the diagnosis codes in general do not include “function diagnosis.” By “function diagnosis,” AOTA is referring to those limited ICD-9 codes that specifically describe the performance deficit for which the occupational therapy intervention is provided. For example, a patient that is initially diagnosed by her physician as having Parkinson’s Disease (332.0) may be referred to occupational therapy for lack of coordination due to ataxia (781.3) to improve muscle tone and enhancing functional abilities through a program of self-dressing and grooming using compensatory techniques. A code, such as 781.3 may be the best available ICD-9-CM treatment code, but other functional codes, such as “difficulty in dressing due to physical (or mental) limitations”, “difficulty in eating due to physical (or mental) limitations”, or “behavioral disorder when performing activities of daily living (ADLs) due to mental health condition” would be more precise for describing the condition for which occupational therapy is provided. Functional or occupational therapy treatment diagnoses, when loosely articulated in ICD-9-CM, are generally found in the section on *Symptoms, Signs, and Ill-defined Conditions* or as V Codes. Functional coding options are limited, non-specific, and often questioned by Medicare and other payers because of their imprecision in describing the basis for occupational therapy treatment.

AOTA has received numerous complaints from members, especially in skilled nursing facility (SNF) settings, that they often must rely on codes such as “malaise and fatigue (780.7)” or “debility, unspecified (799.3)” when searching for a treatment diagnosis for patients that present with difficulties in ADLs due to a physical impairment. Since prime objectives of the ICD-10 transition are to assure health care professional have better descriptors available to ensure only medically necessary care is provided, AOTA strongly urges CMS to include in ICD-10 coding system a method of coding the functional impairments of patients requiring treatments from rehabilitation professionals such as occupational therapists.

In the past, AOTA has unsuccessfully advocated for the inclusion of additional functional diagnosis codes into the ICD-9 coding system. AOTA requests that as part of the transition to ICD-10, CMS consider the addition of specific functional diagnoses to ICD-10 codes or the adoption of the use of the International Classification of Functioning, Disability and Health (ICF) as outlined below.

### **Use of the International Classification of Functioning, Disability, and Health (ICF) to Identify Therapy Diagnoses**

The ICF can establish a common language for describing health and health-related states to improve communication and comparison across health care disciplines and to ensure a patient-centered plan of care. The domains of the ICF are classified from body, individual and societal perspectives by means of two lists: a list of body functions and structure, and a list of domains of activity and participation. Since an individual’s functioning and disability occurs in a context, the ICF also includes a list of environmental factors. Since ICD-10 and ICF are both products of World Health Organization’s framework for classifying and organizing health conditions, AOTA views incorporation of the ICF into the diagnostic

coding system as a logical next step toward a more robust and descriptive health care classification system.

AOTA understands that Dr. Harry Feliciano, Palmetto GBA Director of Part A Medical Affairs, has been using the ICF framework to develop case scenarios and other resources to educate providers to document reasonable and necessary Medicare Part A services with significant success in the North Carolina and South Carolina regions. Dr. Feliciano has identified documentation as a critical area for improvement with respect to therapy services and is using the ICF to teach therapists a new way of thinking about how to appropriately document the services they provide. A similar innovative method of classifying patients based on the categories described in the ICF can be incorporated into ICD-10. Provider education would be necessary to provide a foundational understanding of the ICF construct. AOTA believes strongly that CMS investment in the ICF would be a meaningful and fruitful endeavor to better understanding the types of patients and conditions that rehabilitation clinicians treat.

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AOTA requests that due consideration be given to these comments. Thank you for the opportunity to comment on the ICD-10 Proposed Rule. AOTA looks forward to a continuing dialogue with CMS on coding, coverage, and payment policies that affect the ability of occupational therapists to provide quality care to Medicare beneficiaries.

Sincerely,



Sharmila Sandhu, Esq.  
Regulatory Counsel