**ICD-10-CM and IPPS Regulatory Mapping: An Opportunity for Change**

Each fall we join our Revenue Cycle, Quality, and Coding colleagues in a race to read and understand the impacts of the newest ICD-10-CM coding changes and the Inpatient Prospective Payment System (IPPS) final rule. As we analyze, comment, and often shake our heads at the changes, we wonder whose great idea was that? Who makes these decisions? How does a new code or rule happen?

Lost in our questions, we forget that we are part of the answer. We need to continually remind ourselves that we can have influence and impact with these changes. Understanding the process by which codes and rules are developed is key to using our experience and expertise to its’ fullest extent.

As CDI Specialists, we can have a strong collective voice in creating a new codes, DRG assignments, and code designation as a Complication or Comorbidity (CC) or a Major Complication or Comorbidity (MCC). Recommendations for changes come not only from internal government sources, but from the private sector as well. That means that payors, investors, vendors, and others have equal opportunity to recommend and influence change. Given the landscape, it becomes even more important that we understand the regulatory process and engage in changes that benefit our work.

*Coding Changes: The ICD-10-CM Coordination and Maintenance Committee*

The ICD-10-CM Coordination and Maintenance Committee (C&M) is a Federal interdepartmental committee. Representatives from the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS) co-chair the biannual ICD-10-CM C&M meetings. Responsibility for maintenance of the ICD-10-CM is shared between these two agencies, with NCHS having lead responsibility for diagnostic codes and CMS having lead responsibility for procedural codes (ICD-10-CM PCS). This shared responsibility is reflected in the two-day meeting format.

The ICD-10-CM C&M is responsible for the contents of the ICD-10 code set. The Committee approves code additions, deletions, or modifications. Suggestions for ICD-10-CM modifications come from both the public and private sectors. Proposals must discuss the clinical need for change, the requested action (new diagnoses not reflected in the current code set, deletions of obsolete codes, need for increased specificity, etc), and the suggested change to the tabular index. Interested parties must submit proposals for modification prior to a scheduled meeting. Final decisions on code revisions are made through a clearance process within the Department of Health and Human Services. No final decisions are made at the meeting.

The biannual nature of the process and the multiple channels for input leads to a series of strict deadlines and timeframes. The process begins with requests for topics, followed by public meetings, public comment, and finally code implementation. The biannual cycles overlap each other. The timeline for the current cycle (ICD-10-CM C&M meeting September 2021) is as follows:

* **June 2021:** Request for topics
* **August 2021**: Agenda issued (CMS webpage)
* **September 2021:** ICD-10 Coordination and Maintenance Committee Meeting (2 days)
* **October/November 2021**: Public comments due for code changes effective April 1 (procedure codes) or October 1 (diagnostic codes), 2021
* **April 2022:** Selected codes take effect; additional new codes referenced in FY 2023 IPPS proposed rule, effective October 1.

These meetings are recorded and can be viewed at the reader’s convenience. One does not need to attend the live presentation. The recording remain archived so if one needs more information at any time regarding the code, the recording is accessible even long after the code proposal was presented. The recordings are also helpful as models for those wanting to submit a code proposal, providing an example of how the case was made for the proposed coding change.

*DRG and CC/MCC Changes: The Inpatient Prospective Payment System*

The ICD-10-CM C&M Committee simply establishes the code set. The way the code set is utilized is ultimately the choice of the user. One important way the code set is used by CMS is within the DRG payment model, whether assigning a specific code within a specific MDC/DRG, or establishing a code as a CC or MCC. These assignments are governed by the IPPS Proposed and Final Rule process.

CMS suggest five ways in which CDI specialists might influence payment systems within the IPPS Rule:

“Create a new MS-DRG: include specified codes, and why you believe a new MS-DRG is necessary. Explain how the current MS-DRG(s) is inappropriate and why the change is needed.

Modify existing MS-DRGs: Tell us if you want to move one or more codes out of an MS-DRG into another MS-DRG, and why.

Add severity levels to existing MS-DRGs: explain why and include relevant data. For severity levels they must meet our 5 criteria (ICD-10-CM Guideline III for reporting additional diagnoses). We would perform this analysis using our claims data.

Change OR status of an ICD-10-PCS code: from non-operating (non-OR) to Operating Room (OR) or vice versa and describe why this should be done.

Change severity level of an ICD-10-CM code: from a non-CC to a CC or MCC or vice versa and describe why this should be done.”

As with the ICD-10-CM process, submissions for code assignments to DRG groups or evaluation of codes for CC/MCC status can come from any private or public entity. However, unlike the prior process, there are no public meetings to discuss these proposals. Instead, proposals are vetted by CMS staff for potential inclusion into the IPPS Proposed Rule. As with the ICD-10-CM proposals, suggestions for the IPPS Proposed Rule should include a clinical explanation of the issue and the suggested change in the code’s DRG or CC/MCC assignment. The initial acceptance of the proposal remains unknown until the IPPS Proposed Rule for the upcoming Fiscal Year (FY) is released in late Spring of the current calendar year.

The annual timeline for the IPPS Proposed and Final Rules is not as defined as the ICD-10-CM process:

* **Fall/winter:** Submission of proposals for inclusion within the upcoming FY IPPS Proposed Rule
* **Late Spring:** Release of the upcoming FY IPPS Proposed Rule
* **Mid-Summer:** Public comments due
* **Late Summer:** Release of IPPS Final Rule
* **IPPS Final Rule effective Oct 1** (start of next FY)

*How to get involved: Where to start?*

We believe that the best place to start learning about these regulatory processes is by listening to an on-line meeting of the ICD-10-CM C&M. Reviewing the Meeting Materials prior to each session will provide an introduction to the nature and format of the proposals, and listening to the discussions will aid in understanding the views of various interests in development of the code set. In addition, the Meeting Materials offer a comprehensive guide to the entire process, including timelines and contact information.

ICD-10-CM Diagnostic Codes (NCHS)

https://www.cdc.gov/nchs/icd/icd10cm\_maintenance.htm

ICD-10-CM PCS Codes (CDC)

https://www.cms.gov/Medicare/Coding/ICD10/C-and-M-Meeting-Materials

The IPPS process is more free flowing, with no public meetings prior to promulgation of the Proposed Rule. Similar to the ICD-10-CM Meeting Materials, each year’s Proposed Rule provides timelines for public comment and rule implementation, as well as contacts for further information or submission of proposal for the following year.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS

*You can do it!*

Find your area of passion and make your voice heard. CDI professionals have a unique view of the rules and regulations and how they impact data-driven healthcare. We challenge each of you to explore the process and take the initiative to make a difference.

(The ACDIS Regulatory Committee thanks Dee Banet, MSN, RN, CCDS, CDIP for leading the effort at regulatory mapping and serving as lead author for this work.)