Committee Debates ICD-10-PCS Implementation

by Sue Prophet, RHIA, CCS

Proposed changes, if approved, would not become effective until October 1, 2002.

The ICD-9-CM Coordination and Maintenance Committee, cosponsored by the National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration), met recently in Baltimore, MD. Donna Pickett, RHIA, (NCHS) and Patricia Brooks, RHIA, (CMS) cochaired the meeting. Proposed modifications to ICD-9-CM were presented and are summarized below. Unless otherwise indicated, the audience generally supported the proposed changes.

Procedures

Complete reports of the procedure portion of the Coordination and Maintenance Committee meetings can be found on the CMS Web site at www.hcfa.gov/medicare/icd9cm.htm. The deadline for comments on procedural proposals is January 10, 2002. Comments may be mailed or e-mailed to Patricia Brooks.[1]

ICD-10-PCS

The majority of the first day of the Coordination and Maintenance Committee meeting was devoted to a discussion of whether or not CMS should name ICD-10-PCS as a national standard, replacing the current ICD-9-CM procedure codes for inpatient hospital use. Organizations were given an opportunity to submit a position paper and make a presentation on this issue. The following 11 organizations made a formal presentation at the meeting: AHIMA, American Hospital Association, Federation of American Hospitals, American Medical Association, American Speech-Language Hearing Association, AdvaMed, Medical Technology Partners, McKesson HBOC, DRG Review, Inc., Ingenix Syndicated Content Group, and Princeton Provider Group.[2]

The presenters generally agreed that ICD-9-CM is obsolete and inadequate for current data needs. All of the presenters except the American Medical Association supported ICD-10-PCS as a replacement for the ICD-9-CM procedure codes. While the other presenters felt that ICD-10-PCS is a significant improvement over ICD-9-CM and substantially meets the characteristics of a procedural coding system outlined by the National Committee on Vital and Health Statistics, the American Medical Association commented that implementation of ICD-10-PCS would add to the regulatory burden faced by physicians and other healthcare providers.

Some presenters, including AHIMA, advocated for a single procedure coding system for both inpatient and ambulatory care. These presenters recommended that a decision on a uniform procedure coding system should be made prior to implementation of ICD-10-PCS. Those presenters who commented on the simultaneous implementation of ICD-10-PCS and ICD-10-CM, including AHIMA, indicated a preference for implementation of both systems at the same time.

Presenters representing technology companies urged rapid adoption of ICD-10-PCS for hospital inpatient procedures. The Benefits and Improvement Act (BIPA) requires new technology to be incorporated into the inpatient prospective payment system in a timely manner. Because ICD-10-PCS incorporates much greater specificity and expandability than ICD-9-CM, the implementation of ICD-10-PCS would help to meet the BIPA requirements through enhanced capability to create unique codes to describe new technology.

The discussion of possible adoption of ICD-10-PCS as a new national code set standard at the Coordination and Maintenance Committee meeting was just the first step in the process necessary for adoption of a new standard. AHIMA will provide updates on future meetings and hearings on this issue.

Administration of High-Dose Interleukin-2 (IL-2)

There is no specific procedure code to uniquely capture the administration of high-dose interleukin-2 (IL-2) therapy. Currently, high-dose IL-2 therapy is assigned to ICD-9-CM code 99.28, Injection or infusion of biological response modifier (BRM) as an antineoplastic agent. High-dose IL-2 therapy is a hospital inpatient-based set of services for treatment of patients with advanced renal cell cancer and advanced melanoma. Currently, this treatment modality is the only approved therapy in stage IV metastatic renal cell carcinoma and the only immunotherapy approved for stage IV metastatic melanoma. Unlike traditional cytotoxic chemotherapies that attack cancer cells themselves, IL-2 enhances the body's defenses by mimicking the way natural IL-2 activates the immune system and stimulates the growth and activity of cancer-killing cells. High-dose IL-2 therapy is performed in highly specialized treatment settings, such as an intensive care unit or bone marrow transplant unit. Unlike most cancer therapies, high-dose IL-2 therapy is associated with predictable toxicities requiring extensive monitoring, though these toxicities have been shown to be manageable during the hospital stay and reversible soon after completion of therapy.

It has been proposed that a new code be created in subcategory 99.7, Therapeutic apheresis or other injection, administration, or infusion of other therapeutic or prophylactic substance, for high-dose IL-2 therapy. A member of the audience commented that it may be necessary to specifically define "high-dose" IL-2 therapy versus "low-dose" therapy. The presenter indicated that patients given high-dose IL-2 are treated in the intensive care unit and require careful monitoring. Low-dose IL-2 therapy should be assigned code 99.28 rather than the proposed new code. It was also suggested that the description for the proposed new code should be broad enough that it will not be limited only to Interleukin-2, in the event advances in medicine produce other similar substances.

Physician Query Forms

It was announced that CMS would be conducting a town hall meeting in July to discuss the use of physician query forms. Query forms are used to ask physicians to clarify or augment diagnostic and procedural information in the medical record. These forms vary considerably in how they are constructed. CMS' position has been that query forms should not be a substitute for medical record documentation. The purpose of this meeting is to discuss the nature of query forms and how they should be constructed and used.

Diagnoses

Complete reports for the diagnosis portion can be found on the NCHS Web site at www.cdc.gov/nchs/about/otheract/icd9/maint/maint.htm. The deadline for comments on the diagnosis proposals is January 10, 2002. Comments may be mailed or e-mailed to Donna Pickett.[3]

Critical Illness Neuropathy

The American Academy of Neurology submitted a proposal for new codes for critical illness neuropathy. Critical illness neuropathy has two components: critical illness polyneuropathy (CIP) and critical illness myopathy (CIM). Synonyms of CIP include neuropathy of critical illness, intensive care neuropathy, and intensive care polyneuropathy. CIP has been increasingly recognized as a major cause of prolonged morbidity associated with sepsis and multiple organ failure. It is presumed secondary to Systemic Inflammatory Response Syndrome (SIRS). CIP is an acute axonal neuropathy, both sensory and motor, with changes that can be demonstrated with conventional electrophysiologic testing. Severe weakness is common, often causing difficulty in weaning from mechanical ventilation. It must be differentiated from spinal cord dysfunction, motor neuron disease, Guillain-Barre syndrome, and CIM. CIP occurs in the presence of sepsis, multi-organ failure, respiratory failure, or SIRS. It occurs in up to 70 percent of septic patients, but not all patients are significantly symptomatic. The criteria for a diagnosis of CIP include the presence of sepsis, multi-organ failure, respiratory failure, or SIRS; difficulty weaning from ventilator or limb weakness; decreased amplitudes of compound muscle and sensory action potentials; widespread denervation potentials in muscle; and normal or mildly increased levels of blood CPK. There is no treatment for CIP, only conservative management. Recovery requires weeks to months. Fifty percent have complete recovery.

CIM is also a cause of difficulty in weaning from mechanical ventilation and prolonged recovery time after illness. Synonyms include myopathy of critical illness, intensive care myopathy, acute quadriplegic myopathy, and acute necrotizing myopathy. CIM often develops in patients who receive both neuromuscular blocking agents and corticosteroids in asthma and organ

transplant patients. Features of CIM include low or normal compound muscle action potentials on EMG, normal sensory nerve action potentials unless they are abnormal from a pre-existing neuropathy, muscles are unexcitable from direct stimulation, and muscle biopsy may be abnormal.

In addition to the proposed new codes for CIP and CIM, any other conditions the patient has (such as respiratory failure) would also be coded. An audience member noted that it would need to be made clear that critical illness neuropathy is a specific diagnosis, not a descriptive phrase. The new codes would be created in subcategory 357.8, Other inflammatory and toxic neuropathy. In addition to the new codes, it has also been proposed that an Index entry be added for SIRS that would direct coders to code 038.9.

Aqueous Misdirection

The American Academy of Ophthalmology has requested a new code for aqueous misdirection. Aqueous misdirection, formerly known as malignant glaucoma, is a particular form of glaucoma that cannot be categorized appropriately as angle-closure or open-angle glaucoma, nor can it really be classified using any existing code from category 365. When a patient has aqueous misdirection, the aqueous flows into the vitreous rather than the anterior chamber of the eye. This condition is difficult to treat and almost invariably requires surgical intervention. The proposed new code would be created in subcategory 365.8, Other specified forms of glaucoma.

Coronary Atherosclerosis in Heart Transplant Patients

As heart transplant patients live longer, there is the possibility that the transplanted coronary arteries will develop atherosclerosis. The current codes for coronary atherosclerosis include disease of native artery and of bypass graft. Though the transplanted arteries are native to the heart itself, they are not native to the patient, nor are they a type of graft in the standard sense. It is presumed that development of atherosclerosis is a natural process, not a complication of the transplant.

Creating a new code in subcategory 414.0, Coronary atherosclerosis, for atherosclerosis of a transplanted coronary artery has been proposed. An alternative proposal is to simply index atherosclerosis of transplanted arteries to the code for native coronary arteries. An audience member suggested that the V code for heart transplant status (V43.2) could be used in conjunction with the code for atherosclerosis of native coronary artery, which would provide the information that the atherosclerosis must be of a transplanted artery.

Heart Failure

Because guidelines have been developed by the Agency for Healthcare Research and Quality in association with the American Heart Association and American College of Cardiology that define systolic and diastolic dysfunction, it has been proposed that category 428 be expanded to establish new codes that would better track patients by the more specific distinctions of heart failure. There are significant differences in treatment for systolic and diastolic heart failure. Heart failure is a clinical syndrome or condition characterized by signs and symptoms of intravascular and interstitial volume overload, including shortness of breath, rales, and edema, or manifestations of inadequate tissue perfusion, such as fatigue or poor exercise. These signs and symptoms result when the heart is unable to generate a cardiac output sufficient to meet the body's demands. The term "heart failure" is not interchangeable with "congestive heart failure" because many patients with heart failure do not manifest pulmonary or systemic congestion.

Heart failure may be considered in two ways: one way is to look at pump failure and symptoms, while another way is to look at myocardial failure based on the cardiac output and ejection fraction. The pump failure may be due to myocardial failure or to other causes that may involve mechanical abnormalities (e.g., high output failure) or altered cardiac rhythm. The degree of myocardial failure is more predictive of mortality than the symptoms related to pump failure.

Another term that may be used to describe heart failure is "acute." While it would be most important to have this designation for congestive heart failure, it is also applicable for the other types of heart failure.

The proposed new codes would allow identification of acute congestive heart failure and differentiation between diastolic and systolic congestive heart failure. The proposal also includes new codes to distinguish diastolic and systolic forms of other types of heart failure. The audience felt that the proposal provided more detailed codes than are necessary and that medical record

documentation may not support this level of detail, resulting in the non-specific codes being used the most. One physician commented that if these new codes are created, ICD-9-CM will be "ahead of the curve" in describing advances in the diagnosis and treatment of heart failure because new physicians are being taught how to determine which type of heart failure the patient has and how the specific diagnosis affects treatment.

Documentation of the specific type of heart failure will improve as these new physicians enter the field. A question was raised as to whether both acute and chronic congestive heart failure should be coded when present. It was suggested that the differentiation between acute and chronic congestive heart failure may be more useful in the outpatient setting, because hospital admissions would most likely be for acute congestive heart failure. It may also be useful to be able to identify acute versus chronic congestive heart failure when the diagnosis is a secondary diagnosis in the hospital inpatient setting.

Dieulafoy Lesion

Dieulafoy lesion, a cause of massive gastrointestinal hemorrhage, is an abnormally large and tortuous submucosal artery that protrudes through a small mucosal defect surrounded by essentially normal mucosa. The hemorrhage results from pressure from the large "caliber-persistent" vessel that erodes the overlying mucosa destroying the exposed vascular wall. It is not common, but when it occurs, the hemorrhage is massive and often requires multiple transfusions, endoscopy, or surgery before this lesion is located and confirmed. Its cause is unknown. It usually occurs in the stomach, but has also been reported in other parts of the gastrointestinal tract. It is difficult to diagnose and is often confirmed using endoscopy and angiography. In the past, the only method of treatment was surgery and the mortality rate was about 80 percent. Advances in other methods of treatment have made it possible to diagnose and treat this condition nonsurgically. These methods include endoscopic treatment by sclerotherapy, electrocoagulation, as well as hemoclip and band ligation of the protruding or bleeding vessel. These nonsurgical treatment methods have improved the survival rate.

Currently, there is an Index entry for "Dieulafoy ulcer" that directs the coder to the code for ulcer of stomach. New codes for Dieulafoy lesion of stomach and intestine have been proposed in subcategories 537.8, Other specified disorders of stomach and duodenum, and 569.8, Other specified disorders of intestine. Because hemorrhage is usually the patient's presenting symptom, gastrointestinal hemorrhage should not be separately coded.

Persistent Fetal Circulation

Persistent fetal circulation is currently only an inclusion term under code 747.89, Other specified anomalies of circulatory system. This condition is a frequent cause of death in newborns. In persistent fetal circulation, a stressed newborn reverts to fetal type circulation during the first days following delivery. This occurs when the newborn's pulmonary arterioles constrict and the ductus arteriosus dilates, resulting in right-to-left shunting through the now patent ductus arteriosus and the reopened foramen ovale. Common causes include asphyxia, meconium aspiration syndrome, acidosis, sepsis, and developmental immaturity. As a consequence of persistent fetal circulation, the newborn becomes hypoxic. The goal of treatment is to reverse the conditions that produced the pulmonary vasoconstriction.

The National Association of Children's Hospitals and Related Institutions (NACHRI) has proposed a unique code for persistent fetal circulation in subcategory 747.8, Other specified anomalies of circulatory system.

Perinatal Conditions

Subcategory 770.8, Other respiratory problems after birth, is one of the highest-volume code categories used for newborn records. It contains many different newborn respiratory conditions that vary in type and severity. Also, many infants suffer from more than one of the conditions included in this subcategory and though these infants have a much more complicated case, there is no current way to show these multiple conditions. NACHRI has proposed that unique codes be created in subcategory 770.8 for primary apnea of newborn, cyanotic attacks of newborn, and respiratory failure of newborn. As part of this proposal, all inclusion terms that relate to lack of oxygen at birth will be removed from this subcategory, because they are more properly indexed to codes in category 768, Intrauterine hypoxia and birth asphyxia. A question was raised regarding the difference between respiratory failure and transient tachypnea of newborn (TTN). TTN is more serious than respiratory failure. Respiratory failure is a hyaline membrane disease.

Subcategory 771.8, Other infections specific to the perinatal period, is also a high-volume code category used for newborns. It includes a broad list of infections ranging from a urinary tract infection to septicemia. Septicemia in a newborn is one of the most serious newborn illnesses and is a cause of death for many neonates. It occurs most often in low birthweight infants, those with decreased respiratory function at birth, and those with high-risk maternal factors. NACHRI has proposed that unique codes be created in subcategory 771.8 for septicemia of newborn, neonatal urinary tract infections, and bacteremia of newborn. An additional code should be assigned for the causal organism, if known.

Currently, bradycardia and tachycardia in newborns, independent of the stress of labor and delivery or other intrauterine complications, cannot be uniquely coded in ICD-9-CM. Though these arrhythmias are always a symptom of a specific condition, the underlying condition is not always immediately known. NACHRI has proposed that a new code for neonatal cardiac dysrhythmia be created in subcategory 779.8, Other specified conditions originating in the perinatal period. Both tachycardia and bradycardia would be included in this new code. Abnormality in fetal heart rate or rhythm complicating labor and delivery and bradycardia due to birth asphyxia would be excluded from the new code.

The existing fifth-digit subclassification for categories 764, Slow growth and fetal malnutrition, and 765, Disorders relating to short gestation and unspecified low birthweight, provides only weights, not weeks of gestation. It has been proposed that current fifth-digit subclassification be limited for use in category 764 and codes 765.0, Extreme prematurity, and 765.1, Other preterm infants. The inclusion terms for these codes will be modified to specify only weight. A new subcategory for weeks of gestation is being proposed in category 765 that will distinguish the weeks from the birthweight. More than one code from category 765 could be assigned for the same admission, because different codes would capture information about birthweight and gestational age.

An additional new code is also being proposed for nonviability due to extreme immaturity. This code would be used as a secondary code with another code from category 765. An audience member suggested that a “use additional code” note for the new codes for weeks of gestation be added under codes 765.0 and 765.1. Some concerns were expressed regarding the proposed new code for nonviability of newborn due to extreme immaturity because it is not always possible to predict whether a newborn is likely to survive.

Fussy Infant and Excessive Crying of Infant

Infants are often brought to the pediatrician’s office or the emergency room for excessive crying or fussiness. Often, no specific problem is identified. Unique codes for these infants have been proposed by the American Academy of Pediatrics to be used as a reason for visit code when no cause can be found. These new codes would be created in subcategory 780.9, Other general symptoms. An audience member suggested that it may be necessary to define “infant” for the use of these codes. An “infant” is usually defined as a patient less than 12 months old, but NCHS agreed to consult the American Academy of Pediatrics for a definition.

Ocular Torticollis

A unique code has been proposed for ocular torticollis. The term “torticollis” refers to an abnormal head posture, regardless of the cause. Torticollis has several different possible causes, including visual conditions such as strabismus, visual field defects, or nystagmus. When head tilting is caused by vision problems, it is referred to as ocular torticollis. An individual with ocular torticollis is either trying to improve his or her vision (as in nystagmus) or he is attempting to maintain binocular vision and central fusion and prevent double vision (as in strabismus). Ocular torticollis can also be a sign of brain tumor or other problems of a serious nature. The proposed new code would be created in subcategory 781.9, Other symptoms involving nervous and musculoskeletal system. An Excludes note for the new code would be added under code 723.5, Torticollis, unspecified.

Torus Fractures

The American Academy of Pediatrics has requested unique codes in subcategory 813.4, Fracture of radius and ulna, lower end, closed, and category 823, Fracture of tibia and fibula, for torus fractures of the radius, tibia and fibula. These buckle fractures are very common in children whose soft bones allow for this type of fracture.

Disruption of Operation Wound

The American Hospital Association has requested an expansion of code 998.3, Disruption of operation wound, because this code does not distinguish between internal and external wounds. The default, if the documentation does not clearly indicate whether the disruption is of an internal or external wound, would be the code for disruption of external operation wound. It there is a disruption of both the internal and external operative wounds, both codes should be assigned.

Personal History of Pre-Term Labor

The American College of Obstetricians and Gynecologists has requested new codes for personal history of preterm labor. This history predisposes a woman to complications in future pregnancies. Two new codes have been proposed, one for a pregnant woman to indicate a high-risk pregnancy, and one for a non-pregnant woman, which would be used as a status code. The code for a woman who is currently pregnant would appear in subcategory, V23.4, Pregnancy with other poor obstetric history, and the code for a woman who is not currently pregnant would appear in subcategory V13.2, Other genital system and obstetric disorders. The need for the proposed code for a woman who is not currently pregnant was questioned, but others felt that this code was important for tracking purposes and the provision of pregnancy counseling.

Supplemental Oxygen Dependency

A request was submitted for a V code to indicate that the patient is dependent on supplemental oxygen. These patients are generally severely disabled or have non-reversible pulmonary disease. The proposed new code would be created in category V46, Other dependence on machines. This code would always be a secondary diagnosis code. The underlying respiratory condition would be sequenced first.

Aftercare Codes

AHIMA's Long Term Care Section requested an expansion of categories V54, Orthopedic aftercare, and V66, Convalescence and palliative care, to differentiate aftercare and convalescence following fractures and joint replacements and to identify the specific site of the fracture or joint replacement. They also proposed the creation of new categories for aftercare and convalescence following surgery on various body systems. The existing aftercare and convalescence codes provide very little information, and so they are problematic for the accurate and detailed data collection needed for the long-term care and home health prospective payment systems. Official coding guidelines require that V codes be used for aftercare after the initial treatment of an acute condition, such as a fracture, which means that these codes apply frequently to nursing home and home health patients.

Three options were presented at the meeting: AHIMA's original proposal, expansion of the V54 category only, and expansion of the V66 category only. AHIMA's original proposal included expansion of both V54 and V66 and distinguished between aftercare for traumatic and pathological fractures. It was noted by NCHS that a definition of "convalescence" needs to be determined to differentiate the use of the V66 and V54 codes. Additional considerations need to be given to any possible overlaps among code V53.7 (Fitting and adjustment of orthopedic devices), category V54 (Other orthopedic aftercare), and category V57 (Care involving use of rehabilitation procedures).

An alternative to an expansion of the V codes would be to change the official coding guidelines to allow the use of the code for the acute condition in conjunction with one of the existing aftercare codes. With the V code sequenced first, this approach would provide the information that this is a healing condition, not the initial encounter for treatment of the acute condition.

The audience expressed that expansion of the V codes would be the best approach for responding to the needs of the long-term care and home health industries. The audience generally agreed that, given the confusion surrounding the definition of "convalescence," it would be best to limit this proposal to the aftercare codes. Work should continue on defining "convalescence." The audience also expressed that it was not necessary to create separate codes for aftercare following traumatic and pathological fractures. The level of detail for the proposed codes for aftercare following surgery on specific body systems was also considered unnecessary. However, it was generally agreed that the aftercare concept for conditions other than fractures, particularly open wounds, needs to be addressed. AHIMA and NCHS will work together to develop a refined proposal based on the comments at the meeting and will bring the proposal back to the November Coordination and Maintenance Committee.

Gene Carrier Status

In October 2001, a new V code category (V83) for "gene carrier status" will become effective. This category is only intended to be used for a carrier state when the individual can pass the gene on to offspring, but will never develop the disease him/herself. This category is not to be used for cases when an individual carries a gene that places him/her at higher risk for someday developing the disease.

It has been proposed that a new code for cystic fibrosis gene carrier be added to this category. This code would primarily be used in the obstetric setting. Audience members raised concerns abut the ramifications of sharing information about a patient's gene carrier status with payers. NCHS noted that codes already exist that have potentially serious privacy implications, and this concern would be addressed through the HIPAA privacy regulations.

Scooter External Cause Code

A new E code has been proposed for falls from non-motorized scooters. Recently, injuries associated with these scooters have increased dramatically. The proposed new code would be created in category E885, Fall on same level from slipping, tripping, or stumbling.

Excludes Notes

Due to the multiple definitions of Excludes notes and the confusion they cause, it has been proposed that the Excludes notes be redefined as either "type 1" or "type 2."

"Type 1" Excludes notes would indicate those codes that cannot be used together on the same record. "Type 2" Excludes notes would indicate those codes that may, if appropriate, be used together on the same record. Members of the audience felt that this approach might result in more, rather than less, confusion. It was suggested that different terminology, such as "does not include," be used for those Excludes notes that mean that both conditions may be coded together on the same record.

Addenda

Proposed October 1, 2002, addenda changes were reviewed. Highlights of proposed revisions include:

- deletion of Excludes note for "chronic asthmatic bronchitis (491.2)" under subcategory 493.2, Chronic obstructive asthma, and addition of inclusion term for "chronic asthmatic bronchitis" under subcategory 493.2
- addition of Excludes note for "head injury NOS with loss of consciousness (850.1-850.5)" under code 959.01, Head injury, unspecified
- addition of note under code V58.83, Encounter for therapeutic drug monitoring, instructing coders to "use additional code for any associated long-term (current) drug use (V58.61-V58.69)"
- revision of Index entry for "day blindness" to direct coders to code 368.10
- addition of Index entries for "dehydration with hypernatremia" and "dehydration with hyponatremia" to direct coders to codes 276.0 and 276.1, respectively addition of Index entry for "premenstrual dysphoric disorder" directing coders to code 625.4
- revision of Index entry for "osteonecrosis" to direct coders to code 733.40
- addition of Index entry for "stasis ulcer without varicose veins" directing coders to code 459.81
- addition of the following drugs to the Table of Drugs and Chemicals: Albuterol, Cocaine, Crack, Ipratropium, and Levalbuterol
- The next meeting of the ICD-9-CM Coordination and Maintenance Committee will be held on November 1-2, 2001. This is the final meeting for discussion of proposed code revisions that will become effective October 1, 2002. Diagnosis and procedure proposals for inclusion on the November agenda must be submitted by September 1, 2001.

Notes

1. Send procedure topics or comments to Patricia Brooks, RHIA, National Center for Health Statistics, ICD-9-CM Coordination and Maintenance Committee, 6525 Belcrest Road, Room 1100, Hyattsville, MD 20782 or e-mail pbrooks@hcfa.gov.

2. AHIMA's position paper can be downloaded from the AHIMA Web site at www.ahima.org, and the position papers from all of the organizations that made presentations at the meeting are available on the CMS Web site at http://www.hcfa.gov/medicare/icd9cm.htm.

3. Send procedure topics to Donna Picket, RHIA, Health Care Financing Administration, CHPP, PPG, Division of Acute Care, Mail Stop C4-07-07, 7500 Security Boulevard, Baltimore, MD 21244-1850 or e-mail dfp4@cdc.gov.

Sue Prophet is AHIMA's director of coding policy and compliance. She can be reached at sue.prophet@ ahima.org.

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