

EXAMINING ICD-10 IMPLEMENTATION

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED FOURTEENTH CONGRESS
FIRST SESSION

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²The report has been retained in committee files and also is available at <http://docs.house.gov/meetings/IF/IF14/20150211/102940/HHRG-114-IF14-20150211-SD006.pdf>.

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WEDNESDAY, FEBRUARY 11, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:16 a.m., in room 2322 of the Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Guthrie, Barton, Whitfield, Shimkus, Burgess, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Green, Butterfield, Castor, Sarbanes, Schrader, Kennedy, Cárdenas, and Pallone (ex officio).

Staff present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Leighton Brown, Press Assistant; Jerry Couri, Senior Environmental Policy Advisor; Andy Duberstein, Deputy Press Secretary; Robert Horne, Professional Staff Member, Health; Chris Sarley, Policy Coordinator, Environment and the Economy; Adrianna Simonelli, Legislative Clerk; Heidi Stirrup, Policy Coordinator, Health; Traci Vitek, Detailee, Health; Ziky Ababiya, Democratic Policy Analyst; Jeff Carroll, Democratic Staff Director; Tiffany Guarascio, Democratic Staff Director and Chief Health Advisor; Ashley Jones, Democratic Director, Outreach and Member Services; and Arielle Woronoff, Democratic Health Counsel.

Mr. PITTS. The subcommittee will come to order. The Chair will recognize himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

The United States currently operates under the International Classification of Diseases, 9th Revision (ICD-9) code set, which has about 13,000 diagnostic codes. The Department of Health and Human Services (HHS) had set a mandatory deadline of October 1, 2013, for providers to switch from ICD-9 to the greatly expanded ICD, 10th Revision (ICD-10) code set, which has 68,000 diagnostic codes and 87,000 procedural codes.

Section 212 of H.R. 4302, the Protecting Access to Medicare Act, signed into law by President Barack Obama on April 1, 2014, delayed the transition to ICD-10 until October 1, 2015. Many providers and payers, including the Centers for Medicare and Medicaid Services, have already made considerable investments in the ICD-10 transition, and any further delay will entail additional

costs to keep ICD–9 systems current, to retrain employees, and to prepare, again, for the transition.

The United States currently lags behind most of the rest of the world, which already uses the updated ICD–10. ICD–9 is more than 30 years old and does not capture the data needed to track changes in modern medical practice and healthcare delivery.

I would like to welcome all of our witnesses today. We look forward to your testimony on this important subject.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The subcommittee will come to order.

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I would like to welcome all of our witnesses today. We look forward to your testimony on this important subject.

Mr. PITTS. With that, I will yield back and recognize the ranking member of the subcommittee, Mr. Green, for 5 minutes.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, and good morning and thank you to all our witnesses for being here today.

As we know, ICD–9 was adopted in the United States nearly 40 years ago. Congress included a requirement that providers transition to ICD–10 in the Health Insurance Portability Act of 1996. Since then, transition has been delayed twice to give covered entities time to prepare. ICD–10 transition is currently set to take place on October 1, 2015. It is time to move forward without further delay.

ICD–9 was developed in 1979 and there has been significant medical breakthroughs which ICD–9 doesn't have codes. ICD–10 will include the more accurate medical descriptions and account for varying symptoms and levels of severity. More precise and appropriate codes have a number of benefits to our healthcare system. Precise information will improve claims processing. Insurers will reject fewer claims and not have to ask to provide more information as often as they currently do. The improved specificity of ICD–10 will help researchers. It will allow public health officials to better track disease and outbreaks.

The Affordable Care Act included provisions to move our healthcare system from one that rewards value instead of just volume. There is still a lot of work to do to improve our system in this regard, and adopting ICD-10 without delay would help move this forward.

Providers are increasingly evaluated and held accountable based on patient outcomes so more accurate codes can help providers improve their patient safety efforts.

RAND estimated that the cost of transitioning would be between \$475 million and \$1.5 billion over 10 years but that the benefits of the system would be between \$700 million and \$7.7 billion in cost savings. According to their analysis, this is due to more accurate payments, improved disease management, less rejected claims and fewer fraudulent claims. The transition to ICD-10 is supported by a majority of the healthcare community, a broad-based coalition including hospitals, health plans, medical device manufacturers, and the health information community opposes any further delay. Each has invested substantial time and resources, and further delay will be costly and wasteful.

I understand the medical community has had mixed reactions to the transition. Many have invested time and resources to be ready for October 1st yet some tell us they are not ready. The Centers for Medicare and Medicaid Services says it is ready for the transition. CMS has a technical assistance Web site that features resources to help providers and others with the transition to ICD-10. It has engaged in targeted outreach to facilitate the switch. Between CMS and the Coalition for ICD-10, the resources available to help the transition are significant. Many of these are available online for free.

Each delay has been costly to the healthcare system, and ICD transition is an important part of bringing our healthcare system into the 21st century, and I yield back my time. Wait a second. Does anyone want my time on our side? I yield back my time, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman, and now recognizes Dr. Burgess, 5 minutes for an opening statement.

**OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A
REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS**

Mr. BURGESS. Thank you, Mr. Chairman. I appreciate the recognition. I appreciate our witnesses being here and spending time with us this morning at this hearing. I am certainly glad we are having the hearing. It is something that I have been asking for for some time. I am very glad we are here today talking about our readiness and preparedness and have not delayed that until September.

While the transition has been delayed several times by various mechanisms, the last-minute delays do nothing to relieve the pressure for the small practice that struggles under this administrative burden. It does put the health systems and the insurers in a difficult position as well. In fact, it punishes those who have done exactly what Congress has requested.

So we do need to hear from our witnesses. Are we doing this or not? If we are, then the big question for you and me becomes, will we be ready?

Now, I understand that most of the claims processing will be done by Medicare contractors and insurance companies. I actually have a great deal of faith in their ability to move data. That is what they do. But all roads eventually lead to the Centers for Medicare and Medicaid Services, and if you will pardon me, that does appear to be a weak link in the chain, because from healthcare.gov to the Sunshine Act reporting Web site, when CMS flips a switch, something breaks, and it is invariable, and it has happened time and again. Any time they flip a switch and it involves the processing of data, their systems fail.

So it begs the question: Is flipping a switch on October 1st the right move? If it is, then what is the contingency plan for any problems that may develop? Now, contingency plan is a phrase I use advisedly because it has been in this subcommittee and in the Oversight Subcommittee time and again. With the lead-up to healthcare.gov, I asked Gary Cohen, I asked Secretary Sebelius, what are the contingency plans if all does not go well when you turn this thing on, and I was told no contingency plan necessary, we will be ready October 1st. That was October 1st, 2013. We know what happened after that.

So forgive me if I keep repeating the point that I have asked for contingency plans in the past, I have been told they are not necessary, that everything is fine, until it isn't, and then we all scramble. In this case, it could mean disruptions in patient care and the ability of small practices to actually meet their fiscal obligations that they are required to meet to stay in business.

So today I am anxious to discuss not just the plan ahead for the implementation but I would also like to talk about the contingencies if everything doesn't go exactly as planned.

Thank you, Mr. Chairman, for the recognition. I will yield back the time.

Mr. PITTS. The Chair thanks the gentleman. That concludes the opening statements. As usual, all members' written opening statements will be made a part of the record.

I would like to ask unanimous consent to submit seven documents for the record: a statement on ICD-10 from the American Hospital Association; a letter of support from the ICD-10 Coalition; a statement from the Premier Healthcare Alliance on ICD-10; comments from the American Medical Association; comments from the American Academy of Dermatology Association; statement from the American Academy of Orthopedic Surgeons; and a statement from Precyse, a leader in performance management and technology focused on health information management. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. We have one panel before us today. I will introduce them at this time in the order that they speak: Dr. Edward Burke from the Beyer Medical Group; Mr. Rich Averill, Director of Public Policy at 3M Health Information Systems; Ms. Sue Bowman, Senior Director for Coding Policy and Compliance at American Health Information Management Association; Ms. Kristi Matus, Chief Fi-

nancial and Administrative Officer at Athena Health; Ms. Carmella Bocchino, Executive Vice President, Clinical Affairs and Strategic Planning at America's Health Insurance Plans; Dr. William Jefferson Terry, a Member of the American Urological Association, a Physician at Urology and Oncology Specialists; and Dr. John Hughes, Professor of Medicine at Yale University.

Thank you all for coming. Your written statements will be made a part of the record. You will each be given 5 minutes to summarize your testimony, and we will start with you, Dr. Burke. You are recognized, 5 minutes for your summary.

STATEMENTS OF EDWARD BURKE, M.D., BEYER MEDICAL GROUP; RICHARD F. AVERILL, DIRECTOR OF PUBLIC POLICY, 3M HEALTH INFORMATION SYSTEMS; SUE BOWMAN, SENIOR DIRECTOR, CODING POLICY AND COMPLIANCE, AMERICAN HEALTH INFORMATION MANAGEMENT ASSOCIATION; KRISTI A. MATUS, CHIEF FINANCIAL AND ADMINISTRATIVE OFFICER, ATHENA HEALTH; CARMELLA BOCCHINO, EXECUTIVE VICE PRESIDENT, CLINICAL AFFAIRS AND STRATEGIC PLANNING, AMERICA'S HEALTH INSURANCE PLANS; WILLIAM JEFFERSON TERRY, SR., M.D., LEGISLATIVE AFFAIRS COMMITTEE MEMBER, AMERICAN UROLOGICAL ASSOCIATION; AND JOHN S. HUGHES, M.D., PROFESSOR OF MEDICINE, YALE SCHOOL OF MEDICINE

STATEMENT OF EDWARD BURKE

Mr. BURKE. Good morning, and thank you for the opportunity to share our journey into ICD-10. My name is Dr. Edward Burke. I practice internal medicine in a small, rural community in Missouri with a population of about 4,000 people. I work with a family practice physician, three nurse practitioners, and a mental health provider. We see patients of all ages.

Providers face unique challenges while serving in rural areas due to accessibility and lack of resources. The challenges to running a successful business in healthcare can be just as difficult for the same reasons. The information highway often overlooks the side roads. In an industry full of rules and regulations, it is imperative to keep abreast of anything new coming down the pipe. Being out of the loop often means being left behind.

ICD-10 has been on the horizon for several years now. We were ready for it, and our software vendor was ready for it. When the date was postponed, we moved forward. We believed the implementation of ICD-10 would eventually happen and that we would be even more prepared. With all the changes coming in healthcare, this was one we would tackle in full confidence. What we were unprepared for was how seamless it was. On a busy Monday morning, October 7, 2013, we took on ICD-10 and we haven't looked back. We did not have special training. We did not spend any money in preparation. We did not see less patients and our practice did not suffer. As providers, it was not frustrating or scary. It just was.

Why did this work so well for us? A combination of things in our opinion, most of all teamwork and leadership. We have providers who work well with each other and with the rest of the staff. We

are a close-knit medical office family, understanding that we are only as strong as our weakest employee.

It is important to have a leader on the staff that is progressive and knowledgeable about what is coming, someone who comes prepared with a plan of action. No office should be without a professional practice manager, one who has certification to back up what years of experience has given. The relationship between professional practice managers and physicians is critical and often means the difference in success and failure.

Associations such as PAHCOM offer practice managers the knowledge needed to navigate through the many changes in rules and regulations. Our industry is riddled with what you can do and what you cannot do. PAHCOM provides access to information critical to running a successful medical office.

The other prominent factor was our software. We chose to implement highly effective software when we made the decision to transition to electronic medical records. Our practice manager looked at some of the things coming in the near future and chose software that would grow and expand to what we would need and that would be ready when we needed it. The road to ICD-10 was driven by our EHR vendor. They extended an offer to us to be a part of a pilot program for implementing ICD-10. We were very happy to be a part of it. Our thinking was, it gives us time to play with it and learn it before it really counts. We had no idea how easy it was going to be. We just wanted to take advantage of every possible source of information before each stroke counted financially. We did not feel we could be too prepared. We were as apprehensive as everyone else. Communication is the most important tool in eliminating errors, providing quality care and improving outcomes. There are several pieces that must come together, with the same information, in order to complete one simple procedure.

Speaking the same language is crucial to patient care. ICD-10 is that language. As all processes change and improve over time, so should our diagnosing. ICD-10 provides clear, concise descriptions of the problem a patient is having. The specifications narrow margins of error since the picture is clearer. The drill-down structure of the system provides an accurate description of the problem.

As the world becomes ever smaller it is important to see healthcare with a broader view. Even in our small community, it is not uncommon for patients to be traveling outside of the country. It is important to understand that we are affected by the health of locations outside our homes. To speak the same healthcare language is imperative. As a Nation, we are behind. As an industry, we are behind. As healthcare providers, we can do better. We must be open to change and to the possibility that a different way can work. ICD-10 is truly better than what we currently have. The benefits to ICD-10 have been well touted as well as the drawbacks. We do not claim to have to have the answers or formula that will work for every provider situation but it worked for us.

We used ICD-9 on a Friday and ICD-10 on the following Monday. We are very pleased with our decision to keep using ICD-10 and encourage others to support this move. Accuracy and positive outcomes are of course important goals in patient care. Fine-tuning

diagnoses help paint a clearer picture of what is happening with a patient.

The important thing to understand is that ICD-10 helps, not hinders, patient care. There are many issues that are debatable in healthcare today. Anything that so clearly helps the patient should not be one of them. ICD-10 should move forward. Healthcare moves fast. You cannot blink. Putting off ICD-10 is not blinking; it is closing your eyes.

We do not wish to discredit rational objections to transitions to ICD-10. Each situation will present its own pains and struggles. We just wish to share our story and maybe ease some lingering fear. It wasn't hard, it wasn't expensive and it wasn't time consuming. Clinical documentation did not change. We spend the same amount of time documenting to support ICD-10 as we did with ICD-9. We did nothing different. We use it every day. It is a normal part of our encounter with a patient. The most important issue was that it was not disruptive to patients.

We strongly support full implementation of ICD-10. We believe ICD-10 is a better communication tool and we believe it will truly be a benefit in the care of patients.

Thank you again for the opportunity to share our experiences.

[The prepared statement of Dr. Burke follows:]

Tuesday, February 10, 2015

Coalition for ICD-10

Good Afternoon and thank you for the opportunity to share our journey into ICD-10. My name is Dr. Edward Burke. I practice Internal Medicine in a small rural community in Missouri with a population of about 4,000 people. Along with Dr. Beyer, 2 nurse practitioners, a pediatric nurse practitioner and a mental health provider, we manage to see patients of all ages. From birth to geriatrics we cover it all. As a family practice clinic we see a little of everything. Not exactly the hotbed of excitement or on the cutting edge of anything. And still, we have patients who need the same kind of care as patients all over the country.

Providers face unique challenges while serving in rural areas due to accessibility and lack of resources. The challenges to running a successful 'business' in healthcare can be just as difficult for the same reasons. The information highway often overlooks the side roads. In an industry full of rules and regulations it is imperative to keep abreast of anything new coming down the pipe. Being out of the loop often means being left behind. It is with this in mind that our practice strives to stay on top of the ever changing rules and regulations in healthcare.

ICD-10 has been on the horizon for several years now. We were ready for it. More importantly, our software vendor was ready for it. When the date was postponed, we moved forward. We believed the implementation of ICD-10 would eventually happen and that we would be even more prepared. With all the changes coming in healthcare, this was one we would tackle in full confidence. What we were

unprepared for was how seamless it was. On a busy Monday morning, October 7, 2013 we took on ICD-10 and we haven't looked back.

We did not have special training. We did not spend ANY money in preparation. We did not see less patients and our practice did not suffer. As providers, it was not frustrating or scary. It just 'was'.

Why did this work so well for us? A combination of things in our opinion, most of all teamwork and leadership. We have providers who work well with each other and with the rest of the staff. We are a close knit medical office family, understanding that we are only as strong as our weakest employee. Everything we do in the office we do together. Every staff member is a part of every change in one way or another. It is important to have a leader on the staff that is progressive and knowledgeable about what is coming. Someone who comes prepared with a plan of action. No office should be without a professional practice manager. One who has certification to back up what years of experience has given. The relationship between professional practice managers and physicians is critical and often means the difference in success and failure. Associations such as PAHCOM, Professional Association of Health Care Office Management, offer practice managers the knowledge needed to navigate through the many changes in rules and regulations. Our industry is riddled with what you can do and what you cannot do. PAHCOM provides access to information critical to running a successful medical office.

The other prominent factor was our software. We chose to implement highly effective software when we made the decision to transition to electronic medical records. Our practice manager looked at some of the things coming in the near future and chose software that would grow and expand to what we would need and that would be ready when we needed it. The road to ICD-10 was driven by our EHR

vendor. They extended an offer to us to be a part of a pilot program for implementing ICD-10. We were very happy to be a part of it. Our thinking was: it gives us time to play with it and learn it before it really counts. We had no idea how easy it was going to be. We just wanted to take advantage of every possible source of information before each stroke counted financially. We did not feel we could be too prepared. We were as apprehensive as everyone else.

Communication is the most important tool in eliminating errors, providing quality care and improving outcomes. There are several pieces that must come together, with the same information, in order to complete one simple procedure. Speaking the same language is crucial to patient care. ICD-10 is that language. As all processes change and improve over time so should our diagnosing. ICD-10 provides clear, concise descriptions of the problem a patient is having. The specifications narrow margins of error since the picture is clearer. The drill down structure of the system provides an accurate description of the problem.

As the world becomes ever smaller it is important to see healthcare with a broader view. Even in our small community it is not uncommon for patients to be traveling out of the country. It is important to understand that we are affected by the health of locations outside our homes. To speak the same healthcare language is imperative. As a nation we are behind. As an industry we are behind. As healthcare providers we can do better. We must be open to change and to the possibility that a different way can work. ICD-10 is truly better than what we currently have. The benefits to ICD-10 have been well touted as well as the drawbacks. We do not claim to have to have the answers or formula that will work for every provider situation.

But it worked for us. We used ICD-9 on a Friday and ICD-10 on the following Monday. No training, no expensive consultants, just a dedicated group of professionals who accepted the challenge. And what we got was a normal day at the office. We are very pleased with our decision to keep using ICD-10 and encourage others to support this move. Accuracy and positive outcomes are of course important goals in patient care. Fine tuning diagnoses help paint a clearer picture of what is really happening with a patient. The important thing to understand is that ICD-10 helps not hinders patient care. There are many issues that are debatable in healthcare today. Anything that so clearly helps the patient should not be one of them. ICD-10 should move forward. Healthcare moves fast. From advancements in medicine to the technology in the office, you cannot blink. Putting off ICD-10 is not blinking; it's closing your eyes.

We do not wish to discredit rational objections to transitions to ICD-10. Each situation will present its own pains and struggles. We just wish to share our story and maybe ease some lingering fear. It wasn't hard, it wasn't expensive and it wasn't time consuming. Clinical documentation did not change. We spend the same amount of time documenting to support ICD-10 as we did with ICD-9. We did nothing different. We use it every day; it is a normal part of our encounter with a patient.

We strongly support full implementation of ICD-10. We believe ICD-10 is a better communication tool and we believe it will truly be a benefit in the care of patients.

Thank you again for the opportunity to share our experiences.

Mr. PITTS. Thank you, Dr. Burke.
The Chair now recognizes Mr. Averill, 5 minutes for an opening statement.

STATEMENT OF RICHARD F. AVERILL

Mr. AVERILL. 3M appreciates the opportunity to testify this morning.

ICD-10: We need it. We are ready. This is the message I want to make sure that I convey to the committee today.

The current system used for reporting diagnosis and procedures, ICD-9, was developed nearly 40 years ago. When ICD-9 was developed, you could smoke in a patient's room. There was no personal computer. There was no Internet. Minimally invasive procedures were not even envisioned.

ICD-9 reflects medicine of a bygone era. With ICD-9, we often don't know what is really wrong with the patient or what procedures were performed. ICD-9 codes like a repair of an unspecified artery by an unspecified technique are virtually useless for establishing fair payment levels and evaluating outcomes.

I was one of the original developers of the DRGs at Yale University. Since the inception of the Medicaid Inpatient Prospective Payment System by President Reagan and Speaker O'Neill, I have worked with CMS to maintain and update the DRGs. The biggest frustration with DRG updates is that proposed DRG modifications from the healthcare industry often cannot even be evaluated because there are no ICD-9 codes available.

Congress rightly wants to move to a healthcare system that focuses more on value than volume. I am here to tell you, you can't do that with ICD-9. You need ICD-10. It is time to have our diagnosis and procedure coding system reflect modern medicine.

The RAND report commissioned by the National Committee on Vital and Health statistics concluded that the ICD-10 benefits from more accurate payments, fewer rejected claims, fewer fraudulent claims, better understanding of new procedures, and improved disease management would far exceed the cost of implementation. It is time to start realizing those benefits.

The industry is ready. The transition to ICD-10 is supported by the vast majority of the healthcare community—hospitals, health plans, coding experts, physician office managers, vendors, medical device manufacturers, health informatics specialists, and some in the physician community. All support the adoption of ICD-10 in October of 2015.

Unfortunately, the uncertainty over the ICD-10 implementation date means the whole industry has to maintain fully functional systems in both ICD-9 and ICD-10. Maintaining redundant ICD-9 and ICD-10 systems is very costly. Any further delay means more wasted cost. Last year's delay is estimated to have cost the healthcare industry \$6.5 billion.

Perhaps the biggest challenge to a smooth transition to ICD-10 is the uncertainty of the implementation date. It is simply time to end that uncertainty and allow the whole healthcare industry to move forward with a smooth transition.

Questions have been raised concerning the ability of CMS to move forward with ICD-10. For CMS and its fiscal intermediaries,

the implementation of ICD-10 is primarily an update to its claims processing system. While admittedly CMS has encountered some difficulties with newly constructed consumer-facing Web sites, CMS has extensively experience implementing significant updates to its claims processing system. As the recent GAO report demonstrates, CMS has done extensive ICD-10 planning, preparation, testing and outreach. For example, in order to facilitate vendor and hospital ICD-10 preparation, CMS made available a fully operational version of the ICD-10 MS DRG software more than a year ago. Providers, clearinghouse, payers including CMS are all testing and will continue to test. Testing results show that the system is ready for those who have taken the time to prepare.

As I said in the beginning, ICD-10, we need it, we are ready. As a member of the Coalition for ICD-10, we strongly oppose any further delay to the adoption of ICD-10. The Coalition stands ready to help in any way to ensure a successful transition to ICD-10 in October of 2015. Thank you.

[The prepared statement of Mr. Averill follows:]



**Energy and Commerce Committee
Subcommittee on Health
Hearing on “Examining ICD-10 Implementation”
February 11, 2015**

**Written Statement of Richard F Averill, M.S.
Director of Public Policy, 3M Health Information Systems**

3M Company (“3M”) appreciates the opportunity to testify before the Committee on Energy and Commerce, Subcommittee on Health Hearing on “Examining ICD-10 Implementation.”

3M is a large U.S.-based employer and manufacturer established over a century ago in Minnesota. Today, 3M is one of the largest and most diversified manufacturing companies in the world. We are a global company conducting the majority of our manufacturing and research activities in the United States. 3M thanks the Committee for its recognition that health care innovation is happening quickly in the U.S. and for its leadership on trying to get the health care system to keep pace for the betterment of patients. Ensuring that we have a code set that provides better clinical data and accurately reflects care being provided to patients is a critical component in this effort.

ICD10 - We need it – we’re ready. This is the message I want to make sure that I convey to this Committee today.

We need it. If we are to transition the health care system to one that focuses on value over volume, we need ICD-10. If we are to rate hospitals and physicians based on their outcomes, we need ICD-10. If we are to better assess what procedures, technologies, or approaches best aid improving patient care, we need ICD-10.

We’re ready. The transition to ICD-10 is supported by the majority of the health care community – hospitals, health plans, coding experts, physician office managers, vendors, medical device manufacturers, health informatics specialist, the health information technology community, and some of the physician community. We’ve all invested significant time, energy and money into being ready. Providers, clearinghouses, payers – including CMS – are all testing. Testing results show that the system is ready for those who have taken the time to prepare. For those still in need of action, transition is proving to be manageable. The resources available to help with transition – many of which are free and online – are significant. The Coalition for ICD-10, of which 3M is a Member, stands ready to help in any way for those still left needing to take steps to be ready for October.

3M looks forward to working with the Committee on ensuring adoption of ICD-10 in October 2015.

Background on 3M

3M, formerly known as Minnesota Mining and Manufacturing, is an American company currently headquartered in St Paul, Minnesota. The company, created in 1902 by a small group of entrepreneurs, initially began as a small sandpaper product manufacturer. Today, 3M is one of the largest and most diversified manufacturing companies in the world. 3M is home to such well-known brands as Scotch, Scotch-Brite, Post-it®, Nexcare®, Filtrete®, Command®, and Thinsulate® and is composed of five business sectors: Consumer; Electronics and Energy; Industrial; Health Care; and Safety and Graphics.

Ahead of their peers, 3M's founders insisted on a robust investment in R&D. Looking back, it is this early and consistent commitment to R&D that has been the main component of 3M's success. Today, 3M maintains 46 different technology platforms. These diverse platforms allow 3M scientists to share and combine technologies from one business to another, creating unique, innovative solutions for its customers. The financial commitment to R&D equated to \$1.7 billion of R&D spending in 2013 and over \$7.6 billion over the last 5 years. These investments produced high quality jobs for 4400 researchers in the United States. The results are equally impressive with 625 U.S. patents awarded in 2014 alone, and over 40,000 global patents and patent applications.

3M's worldwide sales in 2014 were \$31 billion. 3M is one of the 30 companies on the Dow Jones Average and is a component of the Standard & Poor's 500 Index. This success is attributable to the people of 3M. Generations of imaginative and industrious employees in all of its business sectors throughout the world have built 3M into a successful global company.

3M: Health Information Systems

3M Health Information Systems works with providers, payers and government agencies to anticipate and navigate a changing healthcare landscape. 3M provides healthcare data aggregation, analysis, and strategic services that help clients move from volume to value-based health care, resulting improved provider performance and better patient outcomes. 3M HIS is one of the industry leaders in computer-assisted coding, clinical documentation improvement, performance monitoring, quality outcomes reporting and terminology management.

ICD-10: We Need It

I was one of the original developers of the DRGs at Yale University. Since the inception of the Medicare inpatient prospective payment system by President Reagan and Speaker O'Neill, I have worked with CMS to maintain and update the DRGs. The biggest frustration with DRGs updates is that reasonable proposed DRG modifications from the health care providers often cannot be considered because there are no ICD-9 code to available to evaluate the proposal. Congress rightly wants to move the health care system to focus more on value over volume. I'm

here to tell you – you can't do it with ICD-9. You need ICD-10. It is simply time to have our diagnosis and procedure coding system reflect modern medicine.

The RAND report commissioned by the National Committee on Vital and Health Statistics concluded that the ICD-10 benefits from more accurate payments, fewer rejected claims, fewer fraudulent claims, better understanding of new procedures, and improved disease management would far exceed the cost of implementation. It is time to start realizing those benefits.

ICD-10 is a long overdue replacement for the outdated ICD-9-CM system for reporting diagnosis and procedure information. If we are to rate hospitals and physicians based on their outcomes, we need ICD-10. If we are to better assess what procedures, technologies, or approaches best aid improving patient care, we need ICD-10.

ICD-9 lacks adequate information to establish fair payment and judge quality. ICD-9 was developed nearly 40 years ago. When ICD-9 was developed you could smoke in the patient's room, there was no personal computer, no internet and minimal invasive endovascular and laparoscopic procedures were not even envisioned. ICD-9 reflects medicine of a bygone era. The reality is with ICD-9 we often don't know what really is wrong with the patient or what procedures were performed. ICD-9 codes like a repair of an unspecified artery by an unspecified technique are virtually useless for establishing fair payment levels or evaluating outcomes.

ICD-10: We're Ready

The transition to ICD-10 is supported by the majority of the health care community – hospitals, health plans, coding experts, physician office managers, vendors, medical device manufacturers, health informatics specialist, the health information technology community, and some of the physician community. We've all invested significant time, energy and money into being ready. Each delay adds substantially to the cost of ICD-10 conversion - the last one year delay is estimated to have cost the health care sector \$6.5 billion dollars. The whole industry has to have fully functional ICD-9 and ICD-10 systems ready to go awaiting the final implementation date from policy makers. CMS has estimated that \$20 billion will be spent getting ready for ICD-10. Because of the long lead times involved in transitioning major software systems, the vast major of those costs have already been incurred and grow with each additional delay.

Questions have been raised concerning the ability of CMS to move forward with ICD-10 implementation. For CMS and its fiscal intermediaries, the implementation of ICD-10 is primarily an update to its claim processing system. In contrast to the difficulties CMS has encountered with consumer facing websites, CMS has extensive experience performing significant updates to its claims processing system. As the recent GAO report demonstrates CMS has done extensive planning, preparation and outreach. The GAO report demonstrates that CMS has been responsive to the concerns of stakeholders and is on track to successfully implement ICD-10. CMS is continuing its program of end-to-end testing to ensure that providers have ample opportunities participate in a complete testing of their ICD-10 readiness. The Blue Cross Blue Shield Association reports that its member plans have completed internal testing and have an end-to-end testing program initiated for providers. Testing results have favorable with

no material problems detected and a successful October 2015 implementation is expected. Providers, clearinghouses and payers are all testing and will continue to test. Testing results demonstrate that the system is ready for those providers who have taken the time to prepare.

For example, because of its in depth use of diagnosis and procedure information and its impact on a \$120 billion in Medicare payments to hospitals, the component of the Medicare claims processing system that present one of the biggest challenges was the conversion of MS-DRGs to ICD-10. In 2012 CMS release the specifications for the ICD-10 version of the MS-DRGs and in 2013 released the ICD-10 MS-DRG software giving the industry ample time for preparation. In addition, CMS has just released a payment impact analysis that concluded that the conversion to ICD-10 will cause negligible changes in MS-DRG payments to hospitals.

For those still in need of action, studies are showing that transition is manageable. The resources available to help with transition – many of which are free and online – are significant. ICD-10 educational materials are now readily available for a nominal cost. Practice specialty specific superbills can be downloaded at no cost from the internet. Many software system vendors are providing ICD-10 system updates at no additional cost. The adoption of electronic health records has further facilitated the transition to ICD-10. The availability of inexpensive support resource has resulted in ICD-10 conversion cost being much lower than initially estimated. The Professional Association of Health-care Office Management (PAHCOM) is the association for managers of physician practices. PAHCOM conducted a survey of its membership to assess the ICD-10 related costs actually being incurred by small physician practices with a focus on practices with six or less direct care providers. This PAHCOM survey found that the average ICD-10 related expenditures per provider for a physician practice with six or less providers is \$3,430. The American Academy of Professional Coders also conducted a survey of the ICD-10 implementation costs in small physician practices (defined by AAPC as under 10 providers) and found that ICD-10 implementation costs averaged \$750 per provider.

Unfortunately, what should be a routine update to the reporting of diagnosis and procedure information has become somewhat overwhelmed in controversy. There are many ICD-10 misconceptions relating to the large increase in the number of codes and codes that will rarely ever be used.

Large number of codes

The notion that a large number of codes create a burden assumes that each provider will have the need to use *all* the codes. However, physicians and other providers will only use the subset of ICD-10 that is relevant to their patient population (i.e., an ophthalmologist will primarily use only the eye codes). Assuming complexity and difficulty of use merely based on the number of codes is like asserting the English language is overly complex and difficult to use because there are 470,000 words in Webster's unabridged English dictionary. Clearly, no one is expected to know and use all 470,000 words. An individual only uses the words he/she needs, and those words constitute a tiny fraction of the words in the dictionary. The same is true for codes. Physicians and other providers will only use the codes relevant to their patient population, and those codes will constitute a tiny fraction of the codes in ICD-10.

Rarely used codes

Because there are some codes that are rarely used there has been the contention that much of the detail in ICD-10 is unnecessary. However, the primary examples of unnecessary detail that are given are from the external cause of injury section of ICD-10, typically dealing with injuries from animals (alligator versus crocodile bite) or extreme causes of injury (sucked into a jet engine). However, except for a very narrow set of external cause codes that deal primarily with medical interventions (surgery on wrong body part), Medicare does not require that physicians or other providers report external cause of injury codes. Further, with the exception of special circumstances like a worker's compensation claim, few other payers require the coding and reporting of external cause of injury codes. Therefore, use of these codes presents minimal, if any, coding and reporting burden for physicians or other providers. Despite the fact that the external cause of injury codes will rarely ever need to be coded and reported, they are used to imply that ICD-10 is riddled with unnecessary detail. Arguing that ICD-10 should be abandoned because a few ICD-10 codes are viewed as unnecessary detail is like arguing that English should be abandoned because it contains the unnecessary word "floccinaucinihilipilification". The ICD-9 external cause codes also contain codes that could be viewed as unnecessary detail (E800.3 Railway accident involving collision with rolling stock and a pedal cyclist). Yet for the last 35 years, the ICD-9 external cause codes have presented minimal if any burden for physicians or other providers.

Summary of 3M Recommendations

We thank the Committee for the opportunity to share our perspective on the need for transitioning to ICD-10.

ICD-10: We need it, We're ready. As a member of the Coalition for ICD-10, a broad-based healthcare industry group that includes hospitals, health plans, hospital and physician office coding experts, physician office managers, vendors, medical device manufacturers, health informatics and information technology leaders, we strongly oppose any further delays to the adoption of ICD-10 in October 2015.

3M stands prepared to work with you in any way we can to support you on this critical coding system upgrade.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Ms. Bowman, 5 minutes for her summary.

STATEMENT OF SUE BOWMAN

Ms. BOWMAN. Good morning. On behalf of the American Health Information Management Association, or AHIMA, I would like to thank you for the opportunity to testify today on the very important topic of ICD-10 implementation.

Implementation of ICD-10 is long overdue. Never before in U.S. history has the same version of ICD been used for more than 30 years. ICD-9 is obsolete and no longer reflects current clinical knowledge, contemporary medical terminology or the modern practice of medicine.

U.S. healthcare data is being allowed to deteriorate while the demand continues to increase for high-quality data, data that can support healthcare initiatives such as the meaningful use of electronic health record Incentive Program, new payment models, and other initiatives aimed at improving quality and patient safety and decreasing costs. ICD-10 also improves tracking and surveillance of pandemic threats such as Ebola, which does not have its own ICD-9 code.

The number of ICD-10 codes has been raised as a concern. The expanded clinical detail in ICD-10 was requested by the medical community because these clinical distinctions were felt to be important to capture. A number of physician organizations continues to actively participate in the ongoing maintenance of ICD-10 by requesting additional clinical detail. Ninety-five percent of the requests for new ICD-10 codes have come from the medical community, especially the physician organizations.

Just as the size of a dictionary or phone book does not make it more difficult to look up a word or a phone number, an increased number of codes does not make it harder to find the right code. Increased specificity, clinical accuracy, and a logical structure actually facilitate rather than complicate the use of a code set. Also, no individual provider will use all of the ICD-10 codes but rather he will use a subset of codes applicable to his clinical practice and patient population. And nearly half of the increase in codes is due solely to the capture of the side of the body affected by the clinical condition.

The specificity of the external cause codes has also been raised as a concern. External cause codes, or the reason why an injury occurred, are not unique to ICD-10. They exist in ICD-9 as well. Many providers are not currently required to report external cause codes unless a provider is subject to a State-based external cause code reporting mandate or these codes are required for a particular patient circumstance. Reporting of external cause codes in either ICD-10 or ICD-9 is not required. And even when external cause codes are required, many of them are for use in very specific circumstances. Most providers have probably had no occasion to assign the existing ICD-9 code for an accident involving injury to the occupant of a spacecraft but the fact that such a code exists has not made ICD-9 more difficult to use.

Many small providers have been concerned about anticipated high cost and complexity of the ICD-10 transition. However, recent

data such as the results of a survey of small physician offices conducted by the Professional Association of Health Care Office Management, or PAHCOM, that were just released yesterday, have shown the cost and burden to be much less than earlier predictions. And physician practices do not need to implement the ICD-10 procedure code or ICD-10 PCS as CPT codes will continue to be used to report physician and outpatient services.

Training is one of the factors in the cost of implementation but the extent of ICD-10 training needed depends on the individual's role. Physicians will primarily require education around the clinical documentation needed to support ICD-10 codes. Additional documentation requirements have often been cited as a major contributor to the cost of ICD-10 implementation. However, even without the ICD-10 transition, there is a growing demand for more complete and accurate documentation, and the impact of clinical documentation improvement efforts can be mitigated through the use of electronic documentation capture tools such as documentation prompts in electronic health record systems. Also, many of the clinical details found in ICD-10 are typically already documented such as laterality.

Free and low-cost ICD-10 educational implementation resources are widely available from multiple sources, giving all stakeholders the ability to be fully ready by the compliance date. Each delay in ICD-10 implementation has taken an enormous toll on the healthcare industry including significant additional costs, diversion of ICD-10 budgets and personnel, lack of employment prospects for students trained in a code set not yet in use, and many lost opportunities to use better data to improve health care and reduce costs.

The healthcare industry has had more than 6 years to prepare. It is time to stop delaying the transition to ICD-10. We need ICD-10, and we are ready.

Thank you for the opportunity to testify.

[The prepared statement and additional material submitted by Ms. Bowman follow:]



Testimony of Sue Bowman, MJ, RHIA, CCS, FAHIMA

On behalf of the

American Health Information Management Association

Before the

Health Subcommittee, Energy and Commerce Committee, U.S. House of Representatives

“Examining ICD-10 Implementation”

February 11, 2015

I am Sue Bowman, Senior Director of Coding Policy and Compliance for the American Health Information Management Association (AHIMA), and I would like to thank the Energy and Commerce Committee’s Subcommittee on Health for the opportunity to testify today on the very important topic of ICD-10 implementation.

AHIMA is a non-profit professional association representing more than more than 101,000 health information professionals who work throughout the healthcare industry. AHIMA plays a leadership role in the effective management of health data and electronic health records needed to deliver quality healthcare to the public. AHIMA is committed to promoting and advocating for high-quality research, best practices, and effective standards in health information. AHIMA and its members work to assure that the health information used in care, research, and health management is valid, accurate, complete, trustworthy, and timely.

Implementation of ICD-10 is long-overdue. We need it – and we’re ready!

Developed in the 1970s, the ICD-9-CM code set no longer fits with the needs of a 21st century healthcare system. Never before in US history has the same version of ICD been used for more than thirty years. ICD-9-CM is obsolete and no longer reflects current clinical knowledge, contemporary medical terminology, or the modern practice of medicine. ICD-9-CM's limited structural design lacks the flexibility to keep pace with changes in medical practice and technology. ICD-9-CM is used for many more purposes today than when it was originally developed and is no longer able to support current health information needs, much less future anticipated demands for detailed, high-quality health information. The ICD-10 code sets have continued to be updated since their original development, ensuring they reflect current medical knowledge and demonstrating that they have much more flexibility to accommodate expansion.

US healthcare data is being allowed to deteriorate while the demand continues to increase for high-quality data that can support new healthcare initiatives such as the "meaningful use" electronic health record Incentive Program, value-based purchasing, and other initiatives aimed at improving quality and patient safety and decreasing costs. Without a switch to a new code set, data on new diseases and technology, or important clinical distinctions in diagnoses and procedures, cannot be accurately captured, limiting the potential to analyze healthcare costs or outcomes, exchange meaningful data for individual and population health improvement, and move to a payment system based on quality and outcomes. ICD-10 also improves tracking and surveillance of pandemic threats such as Ebola which does not have its own ICD-9-CM diagnosis code. By allowing for greater coding accuracy and specificity, ICD-10 is key to collecting the information needed to implement healthcare delivery innovations such as patient-centered medical homes. ICD-10 will enable better patient care through better understanding of

the value of new procedures, improved disease management, and an improved ability to study and understand patient outcomes, yielding benefits to patients far beyond cost savings.

Better data resulting from the use of ICD-10 is expected to lead to:

- Improvements in patient outcomes and patient safety through better data for analysis and research;
- Improved ability to measure outcomes, efficacy, and costs of treatment options, including new medical technology;
- Improved ability to manage chronic diseases by better capturing patient populations;
- More accurate reflection of patients' clinical complexity and severity of illness;
- Improved ability to identify high-risk patients who require more intensive resources;
- Improved ability to manage population health;
- Improved information sharing, which can enhance treatment accuracy and improve care coordination;
- Expanded ability to educate consumers on costs and outcomes of treatment options;
- Enhanced public health surveillance and improvement strategies;
- Improved ability to assess effectiveness and safety of new medical technology;
- Improved administrative efficiencies and lowered costs (e.g., fewer rejected and improper reimbursement claims, decreased demand for submission of medical record documentation);
- Justification of medical necessity;
- More accurate and fair reimbursement;
- More accurate representation of provider performance;
- Increased patient engagement (as a result of access to better data);
- Validation for reported evaluation and management codes; and
- Less misinterpretation by auditors, attorneys, other third parties.

Twenty-five years ago, the National Committee on Vital and Health Statistics (NCVHS) expressed concern that the ICD classification might be stressed to a point where the quality of the system would soon be compromised. More than ten years ago, the NCVHS sent a letter to the Secretary of Health and Human Services (HHS) recommending the ICD-10 code sets be adopted as replacements for the ICD-9-CM code set. Six years have now passed since the final rule adopting the ICD-10 code sets was published.

There is a cost and danger to using the outdated ICD-9-CM code set, and its continued use will increasingly have an adverse impact on the value of healthcare data. Significant costs are being incurred by the delay in replacing ICD-9-CM, including costs associated with:

- Inaccurate decisions or conclusions based on faulty or imprecise data;
- Administrative inefficiencies due to reliance on manual processes;
- Declines in coding productivity and accuracy (due to code ambiguity and outdated terminology); and
- Inability to fully realize the advantages offered by computer-assisted coding technology because ambiguity and lack of precision limit the effective use of this technology.

The decision to mandate ICD-10 was based on years of industry discussions, consensus building, and government rulemaking. Before publishing the proposed rule for the adoption of ICD-10-CM and ICD-10-PCS, the HHS Secretary considered NCVHS recommendations as well as input from federal and state agencies, private and professional organizations, and industry stakeholders, including organizations representing providers, health plans, clearinghouses, and vendors. Between 1997-2003, the NCVHS conducted eight days of hearings

with providers, health plans, clearinghouses, vendors, and interested stakeholders on the adoption of ICD-10-CM and ICD-10-PCS as a replacement for ICD-9-CM.

Several unfounded myths have persistently come up as part of the ICD-10 debate over the years. One of these oft-cited myths is that the increased number of codes in ICD-10 adds unduly to the complexity of implementation. Just as the size of a dictionary or phone book does not make it more difficult to look up a word or phone number, an increased number of codes does not make it harder to find the right code. In fact, the correct code is easier to find in a more comprehensive and detailed code set—just as it is easier to find a word in a comprehensive dictionary. Increased specificity, clinical accuracy, and a logical structure facilitate—rather than complicate—the use of a code set. Also, nearly half (46%) of the increase in the number of codes is due solely to the capture of the side of the side of the body affected by the clinical condition.

The expanded clinical detail in ICD-10 was requested by the medical community because these clinical distinctions were felt to be important to capture. The development of ICD-10 involved extensive input from the healthcare industry, particularly the physician community. A number of physician organizations, including medical specialty societies, continue to actively participate in the ongoing maintenance of ICD-10 by requesting additional clinical detail. Ninety-five percent (95%) of the requests for new ICD-10-CM codes in the past three years came from physician organizations.

No individual provider will use all of the ICD-10 codes. Each provider will use a subset of codes applicable to his clinical practice and patient population. Many of the codes have specific uses, such as for public health or worker compensation cases; these will not be normally used by

many providers. The ICD-10-CM code set is like a dictionary that has thousands of words, but individuals use some words very commonly while other words are never used. Education can be tailored to the subset of codes relevant to the provider.

While there will be a learning curve to become familiar with ICD-10-CM, ultimately it is anticipated that it will be easier to use than ICD-9-CM because of the increased specificity, greater clinical relevancy, and improved logical structure. The improved structure and specificity of the ICD-10 code set will lead to the development of increasingly sophisticated electronic tools to aid the coding process, resulting in improved coding productivity and fewer coding errors. Also, although there are many benefits from the better data produced by the specificity in ICD-10, “unspecified” codes are still available for use when sufficient clinical information is not known or available to report.

The specificity contained in ICD-10 external cause codes has been raised as another concern and as an example of the undue complexity of the ICD-10 code set. External cause codes are not unique to ICD-10. They exist in ICD-9-CM as well. Population-based injury data assist public health authorities in identifying and tracking patterns and trends in the external causes of fatal and nonfatal injuries and in designing and implementing effective injury prevention strategies. However, many providers are not currently required to report external cause codes, and they will not necessarily be required to report them after ICD-10 is implemented, either. There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of external cause codes, in either ICD-10 or ICD-9-CM, is not required.

Even for providers that do report external cause codes, just as with other ICD-10 codes, they will only report those codes that are applicable. Many external cause codes are for use in very specific circumstances. For example, most providers will never see a patient who has been sucked into a jet engine. But this code provides valuable information in a military setting. Most providers have probably had no occasion to assign the ICD-9-CM code for an accident involving injury to the occupant of a spacecraft, but the fact that such a code exists has not made ICD-9-CM more difficult to use.

Another persistent common myth is that there are viable “alternatives” to implementing ICD-10. There are no viable alternatives to implementing ICD-10. Waiting for ICD-11 or using SNOMED-CT in place of ICD has been suggested as an alternative to adoption of ICD-10. Based on the current timeline for completion and release of ICD-11, and the process for adopting and implementing a new code set standard in the US, it would be at least ten years and could be as long as twenty-five years before ICD-11 could be implemented in the US. And that presumes the current World Health Organization ICD-11 timeline does not change. The US cannot wait that long to replace the ICD-9-CM code set. Waiting that long to replace the ICD-9-CM code set would seriously jeopardize the country’s ability to improve quality of care and control healthcare costs. There will always be a new version under development down the road, but in the meantime, the US can reap the many benefits from the version available for implementation today, which is a vast improvement over the version of ICD currently in use. In a 2013 report on the feasibility of skipping ICD-10 and going right to ICD-11, the American Medical Association

Board of Trustees recommended against skipping ICD-10 and moving directly to ICD-11, noting that this approach is fraught with its own pitfalls.¹

Replacing ICD with SNOMED-CT has also been suggested. However, ICD and SNOMED-CT are complementary, not competing, systems. ICD is a classification system and SNOMED-CT is a clinical terminology. Terminologies and classifications are designed for distinctly different purposes and satisfy diverse user requirements. A clinical terminology such as SNOMED CT is an “input” system designed for the primary documentation of clinical care. Classification systems are “output” rather than “input” systems and are not designed for the primary documentation of clinical care. Classification systems group together similar diseases and procedures and organize related entities for easy retrieval. The standard vocabulary afforded by SNOMED CT supports meaningful information exchange to meet clinical requirements. ICD-10, with its classification structure and conventions and reporting rules, is useful for classifying healthcare data for administrative purposes, including reimbursement claims, health statistics, and other uses where data aggregation is advantageous.

Together terminologies and classifications provide the common medical language necessary for interoperability and the effective sharing of clinical data. The ideal situation is to link clinical SNOMED-CT concepts to ICD-10 codes for data reporting purposes where aggregation is preferred. Linked together, ICD-10 and SNOMED CT support better data collection, more efficient reporting, data interoperability, and reliable information exchange in health information systems. ICD-10 and SNOMED CT can both contribute to the improvement of the quality and

¹ American Medical Association. “Evaluation of ICD-11 as a New Diagnostic Coding System.” Report of the Board of Trustees. 2013. <http://www.ama-assn.org/assets/meeting/2013a/a13-bot-25.pdf>.

safety of healthcare and provide effective access to information required for decision support and consistent reporting and analysis.

Many small providers have been concerned about anticipated high costs and complexity of the ICD-10 transition. However, recent survey data involving actual physician practice implementation costs has shown the cost and burden to be much less than had previously been suggested.^{2,3} Physician practices are not affected by the implementation of the ICD-10 procedure code set, ICD-10-PCS, as the American Medical Association's Current Procedural Terminology (CPT[®]) codes will continue to be used to report physician and outpatient services. The extent of ICD-10 training needed depends on an individual's role. While coders will require comprehensive ICD-10 coding education, most physicians will not. Physicians will primarily require education around the clinical documentation needed to support ICD-10 codes. Additional documentation requirements have often been cited as a major contributor to the cost of ICD-10 implementation. However, even without the ICD-10 transition, there is a growing demand for more complete and accurate documentation. And the impact of clinical documentation improvement efforts can be mitigated through the use of electronic documentation capture tools, such as documentation prompts in electronic health record systems. Also, many of the clinical details found in ICD-10 are typically already documented, such as laterality.

Free and low-cost ICD-10 educational and implementation resources are widely available from multiple sources, giving all stakeholders the ability to be fully ready by the October 1, 2015

² Kravis, Thomas, et al. "Cost of Converting Small Physician Offices to ICD-10 Much Lower than Previously Reported." *Journal of AHIMA*, November, 2014. <http://journal.ahima.org/wp-content/uploads/Week-3-PDFpost.FINAL-Estimating-the-Cost-of-Conversion-to-ICD-10-Nov-12.pdf>.

³ Blanchette, Karen, et al. "Survey of ICD-10 Implementation Costs in Small Physician Offices." *Journal of AHIMA*, February, 2015. <http://journal.ahima.org/?p=11119>

ICD-10 compliance date. The Centers for Medicare & Medicaid Services (CMS) have conducted significant industry outreach and developed extensive educational materials and implementation guidance resources targeted to multiple stakeholder groups, including those with limited resources or that have been shown in the past to have been lagging behind in implementation, such as physician practices and small hospitals. CMS has provided in-person ICD-10 training for small physician practices in a number of states.

Many professional associations and organizations have also developed resources and educational programs for stakeholders with limited resources to implement ICD-10. AHIMA is a member of the Coalition for ICD-10, and Coalition members have been, and continue to be, engage in significant efforts to identify and educate those in need of assistance to be ready for the 2015 implementation, including payer-provider collaboratives, training and outreach initiatives, and programs to help coders maintain their new ICD-10 coding skills. AHIMA has worked with its state associations to conduct outreach on ICD-10 implementation to state and local physician organizations and to provide ICD-10 education and implementation assistance to physicians and physician groups.

Every day implementation of ICD-10 is delayed translates to considerable cost to the healthcare industry. All segments of the healthcare industry have dedicated significant time and resources in financing, training, and implementing the necessary changes to workflow and clinical documentation. The repeated ICD-10 delays have been disruptive and costly for healthcare delivery innovation, payment reform, public health, and healthcare spending. Each of these delays has taken an enormous toll on the healthcare industry, including: significant additional costs; diversion of ICD-10 budgets and personnel; lack of employment prospects for students trained in a code set not yet in use; and many lost opportunities to use better data to

improve healthcare and reduce costs. The implementation delays required the ICD-10 conversion work already performed to be updated, retested, and reintegrated – greatly increasing the cost of conversion. The need to retrain personnel and reconfigure systems multiple times in anticipation of the implementation of ICD-10 is unnecessarily driving up the cost of healthcare.

HHS estimated that a one-year delay in the compliance date adds a range of 10 to 30 percent to the total cost that that entities had already spent or budgeted for the transition, equating to a cost to covered entities of \$1.1 to \$6.8 billion for each one-year delay.⁴ The lost opportunity costs of failing to move to a more effective code set also continue to climb every year. The enormous investment that is being made in Accountable Care Organizations (ACOs), meaningful use of electronic health records and value-based purchasing are all predicated on having a more precise and comprehensive diagnosis and procedure coding system that is up-to-date with the rapid changes in practices and technologies utilized in today's healthcare system.

While there have been two delays since the ICD-10 final rule was published in January 2009, the compliance date had already been extended from the original date proposed in the 2008 rule. October 2011 was the compliance date proposed in the 2008 rule, and this date was changed to October 2013 in the final rule as a result of public comments submitted in response to the proposed rule. So the industry initially had more than four years after publication of the final rule to prepare for the ICD-10 transition. As a result of the two one-year delays granted by HHS in 2012 and Congress in 2014, the healthcare industry has had more than six years to prepare. This length of time is more than adequate for all segments of the healthcare industry to be ready

⁴ Department of Health and Human Services. "Administrative Simplification: Change to the Compliance Date for the International Classification of Diseases, 10th Revision (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets; Final Rule." *Federal Register* 79, no. 149 (August 4, 2014). <http://www.gpo.gov/fdsys/pkg/FR-2014-08-04/pdf/2014-18347.pdf>.

for the transition. In reality, the healthcare industry has had even more time to prepare for ICD-10, as the 2008 proposed rule was not the first indication that ICD-10 was coming as a replacement for the ICD-9-CM code set.

In conclusion, it is time to stop delaying the transition to ICD-10 so that US can start reaping the benefits of a more modern code set that the rest of the world has enjoyed for a number of years now. The healthcare industry has had more than enough time to prepare for ICD-10. The way to ensure industry readiness for the compliance date is to send a very clear message that the date is not going to change, because as long as stakeholders anticipate another delay, some organizations will fail to take steps to prepare, even those that were on track. **We need ICD-10 – and we're ready!**

SUMMARY OF KEY POINTS

- We need ICD-10 – and we're ready.
- ICD-9-CM is obsolete and no longer reflects current clinical knowledge, contemporary medical terminology, or the modern practice of medicine.
- Without a switch to a new code set, data on new diseases and technology, or important clinical distinctions in diagnoses and procedures, cannot be accurately captured, limiting the potential to analyze healthcare costs or outcomes, exchange meaningful data for individual and population health improvement, and move to a payment system based on quality and outcomes.
- Significant costs are being incurred by the delay in replacing ICD-9-CM, both in terms of costs directly related to the multiple delays as well as lost opportunity costs associated with failure to transition to a more modern code set. Each one-year delay has added 10 to 30 percent to the total cost that that entities had already spent or budgeted for the transition, or \$1.1 to \$6.8 billion.
- Concerns about exorbitant implementation costs for small providers are not supported by recent survey data.
- The number of codes in ICD-10 does not make the code set more difficult to use than ICD-9-CM.
- Forty-six percent (46%) of the increase in the number of codes is due solely to the capture of the side of the side of the body affected by the clinical condition.
- The clinical detail in ICD-10-CM was requested by the medical community.
- Ninety-five percent (95%) of the requests for new ICD-10-CM codes come from physician organizations.
- There are no viable alternatives to ICD-10.
- The healthcare industry is well-prepared to meet the October 2015 compliance date, and free or low-cost education and implementation resources are widely available to assist small providers in making the transition to ICD-10.
- The way to ensure industry readiness for the compliance date is to send a very clear message that the date is not going to change, because as long as stakeholders anticipate another delay, some organizations will fail to take steps to prepare, even those that were on track.

Clarification on the Use of External Cause and Unspecified Codes in ICD-10-CM

Approved by the four Cooperating Parties for ICD-10-CM/PCS and ICD-9-CM Coding, which includes American Health Information Management Association, American Hospital Association, Centers for Medicare & Medicaid Services, and National Center for Health Statistics

External Cause Codes

Just as with ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. If a provider has not been reporting ICD-9-CM external cause codes, the provider will not be required to report ICD-10-CM codes in Chapter 20, unless a new state or payer-based requirement regarding the reporting of these codes is instituted. Such a requirement would be independent of ICD-10-CM implementation. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

Sign/Symptom/Unspecified Codes

In both ICD-9-CM and ICD-10-CM, sign/symptom and “unspecified” codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). In fact, unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

ICD Timeline**1979**

ICD-9-CM implemented (prior to development and implementation of reimbursement systems that rely on diagnosis and procedure codes)

Although annual update process allows some addition of new conditions and procedures, and expansion for greater detail, it uses as its base a classification system that was developed 40 years ago.

1983

Implementation of hospital inpatient prospective payment system which uses ICD-9-CM diagnosis and procedure codes as the basis for assigning cases to DRGs.

1990

The National Committee on Vital and Health Statistics (NCVHS) issued a report to the Assistant Secretary for Health noting that while the ICD-9-CM classification system has been responsive to changing technologies and identifying new diseases that impact heavily on the community, there was concern that the ICD classification might be stressed to a point where the quality of the system would soon be compromised.

1993

NCVHS sent letter to Assistant Secretary for Health and Administrator of the Healthcare Financing Administration (HCFA) recommending that the Department of Health and Human Services (HHS) dedicate resources to determine the feasibility of implementing ICD-10 for morbidity applications.

ICD-10 was released by the World Health Organization.

1994

NCVHS sends a letter to the Assistant Secretary for Health urging HHS to consider the desirability and feasibility of developing a clinical modification of ICD-10 for morbidity purposes.

The National Center for Health Statistics (NCHS) awarded a contract to the Center for Health Policy Studies to evaluate ICD-10 for morbidity purposes within the U.S. A prototype of ICD-10-CM was developed following a thorough evaluation of ICD-10 by a Technical Advisory Panel comprised of private and public sector stakeholders.

HCFA announced plans to initiate a solicitation for a contract to develop a new procedure coding system for use with hospital inpatients replace the ICD-9-CM procedure codes. This new system is referred to as ICD-10-PCS.

1995-1996

Further work on ICD-10-CM is undertaken by NCHS, including a thorough review of ICD-9-CM Coordination and Maintenance Committee proposals for modifications that

could not be incorporated into ICD-9-CM and extensive collaboration with many medical/surgical specialty groups.

HCFA awards a contract to 3M HIS to develop the procedure classification system to replace Volume 3 of ICD-9-CM (hospital inpatient procedures), known as ICD-10-PCS. It was developed using an open process and a Technical Advisory Panel provided review and comments throughout development. The new procedure classification adheres to the criteria established by NCVHS for a procedure classification system in 1993.

1996-1998

Informal and formal testing of ICD-10-PCS was conducted.

1997

The draft of the Tabular List of ICD-10-CM, and the preliminary crosswalk between ICD-9-CM and ICD-10-CM is made available on the NCHS website for public comment during a three-month open comment period, which begins December 1997 and ends February 1998. More than 1,200 comments are received from 22 individuals and organizations representing a variety of groups, including one governmental agency, two research institutions, three information system developers, four professional organizations, and several health care providers. Comments range from general observations to very specific and detailed analyses.

1997-2003

More than eight days of hearings are held by NCVHS with letters and written and oral testimonies provided by more than 80 public and private sectors groups representing the healthcare industry, the Federal and State governments, public health and research communities, insurers, and providers.

<http://www.ncvhs.hhs.gov/>

<http://www.ncvhs.hhs.gov/031105lt.htm>

AHIMA testimony:

http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok2_000614.hcsp?dDocName=bok2_000614

http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1_013551.hcsp?dDocName=bok1_013551

http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1_013552.hcsp?dDocName=bok1_013552

1998

The Notice of Proposed Rulemaking (NPRM) for Transactions and Code Sets is published by the HHS, as required by the Health Insurance Portability and Accountability Act of 1996. ICD-9-CM is proposed as the initial standard for diagnoses and inpatient procedures. The NPRM includes the following language: *In addition to accommodating the initial code sets standards for the year 2000, those that produce and process electronic administrative health transactions should build the system flexibility that will allow them to implement different code formats beyond the year 2000.*

<http://www.gpo.gov/fdsys/pkg/FR-1998-05-07/pdf/98-11691.pdf>

The ICD-10-PCS coding system, training material and crosswalk to ICD-9-CM procedure codes were posted on the Centers for Medicare and Medicaid Services (CMS) web site. The coding system and related materials have been updated annually since then.

<http://www.cms.gov/Medicare/Coding/ICD10/index.html>

1999

ICD-10 was implemented in the U.S. for mortality reporting.

<http://www.cdc.gov/nchs/icd/icd10.htm>

An overview of the comments received during the ICD-10-CM comment period is posted on the NCHS website in 1999. A summary of the comments also is presented at the November 1999 ICD-9-CM Coordination and Maintenance Committee meeting and posted on NCHS website.

2000

The Final Rule for Transactions and Code Sets is published and states: *ICD-10-CM has great potential for replacement of ICD-9-CM.*

<http://aspe.hhs.gov/admsimp/final/txfinal.pdf>

2000-2001

Further enhancements to ICD-10-CM continue with changes being made in response to the open comment period, as well as, input from physician specialty groups.

2001

In the Benefits Improvement and Protection Act of 2000, Congress addressed requirements for incorporation of new medical services and technologies into the Medicare hospital inpatient prospective payment system. In the September 7, 2001 issue of the *Federal Register*, CMS noted the limitation of ICD-9-CM regarding the ability to expeditiously incorporate new medical services and technologies into the classification. A number of procedural approaches and techniques cannot be readily captured by the structure of ICD-9-CM codes.

<http://www.gpo.gov/fdsys/pkg/FR-2001-09-07/pdf/01-22475.pdf>

2002

CMS states a contract had been awarded to 3M HIS to undertake the DRG conversion necessary when ICD-10-CM and ICD-10-PCS are adopted as national standards.

2003

An updated draft of ICD-10-CM was posted on the NCHS web site.

Under the direction of NCVHS, a contract was awarded to RAND's Science and Technology Policy Institute to conduct an impact analysis of moving to ICD-10-CM and

ICD-10-PCS. This analysis concluded that switching to the new code sets is likely to generate more benefits than costs.
http://www.rand.org/content/dam/rand/pubs/technical_reports/2004/RAND_TR132.pdf

The American Health Information Management Association (AHIMA) and the American Hospital Association (AHA) jointly conduct a pilot test of ICD-10-CM during June/July 2003. The study involves dual coding records in ICD-9-CM and ICD-10-CM. More than 6100 records from a broad cross section of health care community were dual coded by 180+ participants. The results indicated that: there is general support for adoption of ICD-10-CM; ICD-10-CM is seen as an improvement over ICD-9-CM; and ICD-10-CM is more applicable to non-hospital settings than ICD-9-CM.
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_021578.pdf

In July 2003, AHIMA sends letter to HHS Secretary on adoption of ICD-10.
http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1_021545.hcsp?dDocName=bok1_021545

In November 2003, the NCVHS sent a letter to the Secretary of HHS recommending adoption of ICD-10-CM and ICD-10-PCS as HIPAA standards for national implementation as replacements for current uses of ICD-9-CM. NCVHS concludes it is in the best interests of the country as a whole that ICD-10-CM and ICD-10-PCS be adopted as HIPAA standards for national implementation as replacements for current uses of ICD-9-CM volumes 1, 2, and 3.
<http://www.ncvhs.hhs.gov/031105lt.htm>

2003-2011

ICD-10-CM is updated annually every October 1 to accommodate changes made to ICD-10 by the World Health Organization and to incorporate changes made to ICD-9-CM diagnosis codes. ICD-10-PCS is updated annually every October 1 to incorporate changes made to ICD-9-CM, Volume 3.

Current version of ICD-10-CM: <http://www.cdc.gov/nchs/icd/icd10cm.htm>

Current version of ICD-10-PCS:

<http://www.cms.gov/Medicare/Coding/ICD10/index.html>

2004

The NCVHS Workgroup on Quality report titled "Measuring Health Care Quality: Obstacles and Opportunities" noted that the adoption of ICD-10-CM would help with the capture of more specific clinical information on disease severity, including complications, co-morbidities and risk factors. The report recommended adoption of ICD-10-CM.

<http://www.ncvhs.hhs.gov/040531rp.pdf>

2005

Subcommittee on Health of House Ways and Means Committee addresses adoption of ICD-10-CM and ICD-10-PCS as part of a hearing on the use of health information technology.

AHIMA testimony:

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_031217.pdf

Representative Nancy Johnson (CT) introduced H.R. 4157, the “Health Information Technology Promotion Act of 2005,” requiring the replacement of ICD-9 with ICD-10, for transactions occurring on or after October 1, 2009. The intent of this section of the bill was to speed up the implementation of ICD-10-CM/PCS. This section was ultimately removed because HHS agreed to move forward with the regulatory process to implement ICD-10-CM/PCS.

2006

Subcommittee on Health of House Ways and Means Committee holds hearing on the adoption of ICD-10-CM and ICD-10-PCS.

AHIMA testimony:

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_031258.hcsp?dDocName=bok1_031258

2007

Senator Norm Coleman (MN) introduced S. 628, the “Critical Access to Health Information Technology Act of 2007,” requiring the replacement of ICD-9 with ICD-10. The ICD-10 language called for a final rule to be promulgated by October 1, 2008, with full implementation by October 1, 2011.

NCVHS sends a letter to the Secretary titled, “Revision to HIPAA Transaction Standards Urgently Needed.” The letter states that “...there are specific and urgent business drivers (e.g., the need to accommodate ICD-10 codes) that justify adoption of Version 5010.”
<http://www.ncvhs.hhs.gov/070926lt.pdf>

2008

In a letter to the Secretary on “Quality measurement and public reporting in the current health care environment”, NCVHS recommends that the HHS “Accelerate US adoption of ICD-10-CM and ICD-10-PCS by publishing the required notice of proposed rulemaking.”

<http://www.ncvhs.hhs.gov/080128lt.pdf>

HHS publishes an NPRM for replacement of ICD-9-CM by ICD-10-CM and ICD-10-PCS on October 1, 2011.

<http://www.gpo.gov/fdsys/pkg/FR-2008-08-22/pdf/E8-19298.pdf>

2009

HHS publishes a final rule for adoption of ICD-10-CM and ICD-10-PCS on October 1, 2013.

<http://www.gpo.gov/fdsys/pkg/FR-2009-01-16/pdf/E9-743.pdf>

NCVHS conducts a hearing to monitor industry progress on implementation of updated versions of the HIPAA transaction standards and ICD-10 code sets

(<http://www.ncvhs.hhs.gov/091209ag.htm>). Following the hearing, the Committee sends a letter to the Secretary recommending that HHS, “Reiterate in every publication, presentation and public forum, that the deadline for Versions 5010, D.0 and 3.0 is January 1, 2012, and the deadline for implementation for ICD-10 code sets is October 1, 2013. These deadlines have been established by HHS as the law, and there is no justification for changing them. HHS, through CMS, must effectively publicize its commitment to the compliance dates.” (<http://www.ncvhs.hhs.gov/100303lt.pdf>)

AHIMA testimony:

http://library.ahima.org/xpedio/groups/public/documents/government/bok1_046473.pdf

2010

CMS announces a partial code set freeze in preparation for the ICD-10 transition, resulting in the last regular annual update to ICD-9-CM and ICD-10-CM/PCS occurring on October 1, 2011 with only limited code updates to capture new technology and new diseases being implemented until the resumption of regular updates one year after the ICD-10 transition.

http://www.cms.gov/Medicare/Coding/ICD10/downloads/Partial_Code_Freeze.pdf

2011

NCVHS holds another hearing to monitor industry progress on implementation of updated versions of the HIPAA transaction standards and ICD-10 code sets and again recommends to the HHS that “HHS should use all communication vehicles to reiterate and emphasize that the compliance dates for implementing 5010/D.0/3.0 and ICD-10 code sets are not changing.”

<http://www.ncvhs.hhs.gov/110617ag.htm>

<http://www.ncvhs.hhs.gov/110922lt1.pdf>

AHIMA testimony:

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050642.pdf

2012

NCVHS sends letter to HHS Secretary urging that any delay in ICD-10 implementation not be more than a year, due to the significant financial burden that accrues with each month of delay.

<http://www.ncvhs.hhs.gov/120302lt4.pdf>

AHIMA sends letter to HHS Secretary urging that there be no delay in the ICD-10 compliance date.

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050126.pdf

In April 2012, HHS publishes an NPRM to change the compliance date for ICD-10-CM/PCS from October 1, 2013 to October 1, 2014.

<http://www.gpo.gov/fdsys/pkg/FR-2012-04-17/pdf/2012-8718.pdf>

NCVHS holds a hearing on the industry status of planning, transitioning and implementation of administrative transaction standards, code sets and operating rules.

<http://www.ncvhs.hhs.gov/120620ag.htm>

AHIMA testimony:

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_049926.pdf

In September 2012, HHS publishes a final rule that changes the compliance date for ICD-10-CM/PCS from October 1, 2013 to October 1, 2014.

<http://www.gpo.gov/fdsys/pkg/FR-2012-09-05/pdf/2012-21238.pdf>

2013

AHIMA sends letter to HHS Secretary requesting that the previous commitment to only extend the compliance date for ICD-10-CM and PCS to October 1, 2014 be maintained and that the implementation process not be stopped.

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050314.pdf

NCVHS holds hearing on current state of administrative simplification standards, code sets and operating rules and recommends to HHS that it continue to emphasize its intent NOT to change the current deadline for compliance with ICD-10 code sets of October 1, 2014.

<http://www.ncvhs.hhs.gov/130617ag.htm>

<http://www.ncvhs.hhs.gov/130920lt.pdf>

AHIMA testimony:

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050246.pdf

The “Cutting Costly Codes Act,” H.R. 1701 and S. 972, is introduced by Representative Ted Poe (TX) and Senator Tom Coburn (OK), which would prohibit implementation of ICD-10-CM/PCS on October 1, 2014.

2014

NCVHS holds hearing in February on HIPAA and ACA Administrative Simplification, including ICD-10.

<http://www.ncvhs.hhs.gov/140219ag.htm>

AHIMA testimony:

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050612.pdf

In April, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which contains a provision prohibiting the Secretary from adopting the ICD-10 code sets as the standard for code sets prior to October 1, 2015.

<http://www.gpo.gov/fdsys/pkg/BILLS-113hr4302enr/pdf/BILLS-113hr4302enr.pdf>

In August, HHS publishes a final rule implementing section 212 of the Protecting Access to Medicare Act of 2014 by changing the ICD-10-CM/PCS compliance date from October 1, 2014 to October 1, 2015. It also requires the continued use of ICD-9-CM through September 30, 2015.

<http://www.gpo.gov/fdsys/pkg/FR-2014-08-04/pdf/2014-18347.pdf>

Address:

Physician A
Internal Medicine and Family Health Care

Phone:

EIN:

INJECTIONS		OFFICE SERVICES		DIAGNOSIS	
		99201	Office visit, L1, new	R10.9	Abdominal pain
90632	Hepatitis A (dx: Z23)	99202	Office visit, L2, new	R76.81	Abnormal prostate ex.
90746	Hepatitis B (dx: Z23)	99203	Office visit, L3, new	J01.90	Acute sinusitis
90658	Flu Vaccine (dx: Z23)	99204	Office visit, L4, new	R74.0	Abnormal LFT
90732	PneumoVax (dx: Z23)	99205	Office visit, L5, new	J30.9	Allergic rhinitis
				G30.9	Alzheimers
				D64.9	Anemia, unspecified
90178	DT (dx: Z23)	99211	Office visit, L1, estab	I20.9	Angina
90471	Adm Vac or G00008 /9	99212	Office visit, L2, estab	J45.909	Asthma
9078x	Administer Shot or mc-g	99213	Office visit, L3, estab	E53.8	B12 deficiency
	LAB	99214	Office visit, L4, estab	M54.5	Back pain, low
85024	CBC	99215	Office visit, L5, estab	466.0	Bronchitis, acute
85023	CBC+Dif	993XY	Wellness Exam / preventive med	N63	Breast lump
85018	Hct	99080	Special reports	I25.10	CAD
85652	ESR CRP 86140	99058	Seen as emergency	I49.9	Arrhythmia, NOS
85610	PT-INR	G0102+59	Rectal exam-medicare V76.44	L03.90	Cellulitis
81002	UA w/o micro dx v81.6	G0101+59	Gyn/rectal-medicare V76.2	I63.9	CVA
81001	UA w micro dx v81.6	Q0091+59	Collect pap-medicare V76.2	H61.20	Cerumen impaction
80061	Lipid Panel	93000	EKG 99173-stellen-dx	R07.9	Chest pain, unspecified
80076	Liver Panel	20610	Aspirate major joint	R07.89	Chest wall pain
80048	BMP	20550	Inject trigger point	I50.9	CHF
80053	CMP 80050 GHP	17110	Cryo wart	J44.9	COPD
84443	TSH	172	Cryo destruction	R05	Cough
84153	PSA v76.44	69210	Removal impact ear	L30.9	Dermatitis
82947	Glucose	10060	I&D Abcess	E10.9	Diabetes-IDDM
83036	A-1c	9937X	phone service-L	E11.9	Diabetes-Niddm
84450	GOT	93016	ETT perform	K52.9	Gastroenteritis
82550	CPK-total	93018	ETT interp	K57.80	Diverticulosis
82565	Creatinine	93233	Holter interp	R42	Dizziness
86677	H. Pylori antibody-qual	46600	Anoscopy	R06.00	Dyspnea
99000	Stat lab conveyance	GZ or GA to V	add -25 if 59 above + 99	K30	Dyspepsia
88164	Pap smear-mc / v76.2	99995	window pay	R60.9	Edema
82270/g0107	Hemocult x1done exam	99996	no charge visit	N95.11	Estrogen deficiency (symptomatic menopausal state)
82270/g0107	Hemocults x 3 v76.51	99997	same day change	R53.83	Fatigue
36415	Venopuncture or g0001	99998	no show	R50.9	Fever
		x = Dx same as last sb		R51	Headache, NOS
		99375 CPO		G43.9	Headache, migraine
				R31.9	Hematuria
				E78.5	Hyperlipidemia
				I10	Hypertension, essential
				E03.9	Hypothyroidism
				M60.9	Mycofasciitis
				R11.0	Nausea & vomiting
				K21.0	Reflux esophagitis
				G40.909	Seizure disorder
				Z51.81,	Supervise med
				Z79.89	
				I11.9	Hypertensive cardiomyopathy
				G45.9	TIA
				I48.0	Atrial fibrillation
				Z79.0	Long term use anticoag
				Z23	Flu vaccine
				Z00.010	General med exam / wellness exam
				J06.9	URI
				R35.0	Urinary frequency
				K29.70	gastritis

Co-pay=\$20 or
amount paid:

f/u: nt 15 30 1 wk 1 mo 1 yr 60 lab-nt prn for: mir
INR only 1 mo lab only fasting

This sample superbill was converted to ICD-10-CM by the American Health Information Management Association (AHIMA) solely as an exercise in demonstrating the process of transitioning to a new coding system. It does not represent an endorsement by AHIMA of the use of superbills or this superbill format.

Mr. PITTS. Thank you, Ms. Bowman.

At this point the Chair recognizes Ms. Matus, 5 minutes for her summary.

STATEMENT OF KRISTI A. MATUS

Ms. MATUS. Chairman Pitts, Ranking Member Green, members of the subcommittee, thank you for this opportunity to share our perspective on the important issue of ICD-10 implementation and its implications for our broader, bipartisan health reform efforts.

My name is Kristi Matus, and I am the Chief Financial and Administrative Officer for Athena Health, a provider of cloud-based health information technology services to more than 60,000 care providers nationwide in all 50 States, connecting care for over 60 million patients.

Every one of our clients is on a single national Internet-based network that we use to connect with them in real time on a daily basis like Amazon, Facebook or Google. As you may know, this is a paradigm that is all too rare in health care.

Based on our experience with partnering with medical practices to improve efficiency and outcomes, our point of view is simple: it is decision time. Maintain the current date for ICD-10 implementation or cancel it once and for all. Do not allow another delay.

Our Nation has an extraordinarily ambitious, largely bipartisan healthcare agenda. From the effort to transition the Nation's care providers to modern technology to the clear imperative of shifting from a costly fee-for-service model to value-based delivery payment structures, we have collectively resolved to tackle a series of very difficult complex problems, all with the idea of reducing costs and taking better care of patients. To cite just one particularly timely example, the 21st Century Cures package of initiatives championed by many on this committee has tremendous potential to improve health care, but many of its components assume and depend upon continued technological evolution.

I am not here to tell you that ICD-10 is a silver bullet, but on the spectrum of the challenges we face in health care, ICD-10 is a relatively easy one, the technological equivalent of an upgrade from a simple dictionary to a more complex one. It will be orders of magnitude less difficult than achieving the changes in human behavior necessary for the Meaningful Use program to succeed or implementing the fundamental evolution in healthcare business models necessary for truly accountable care. Repeatedly delaying the implementation of relatively simple changes calls into question whether we as a country are truly committed to improving health care and potentially undermines the success of our national healthcare agenda.

Fortunately, we know that ICD-10 is absolutely possible. Much of the developed world has made the switch years ago including, for example, the Czech Republic, Korea and Thailand, where, according to the World Bank, the average annual healthcare spend per capita is \$215 compared to nearly \$9,000 in the United States.

At Athena Health, we have already completed the work necessary to ensure that our clients were ready for last year's deadline as they will be ready for this year's. In fact, we financially guar-

antee ICD-10 readiness for each of our tens of thousands of clients. We are not the only solution.

Many of our clients practice in exactly the kinds of small medical groups that have expressed significant concerns about the changes required to adapt to ICD-10. Each new delay only multiplies the financial and emotional cost of such practices, who struggle not only with the implications of a possible code switch but with the persistent uncertainty created by repeated delays. Fear creates stasis, inhibiting progress not only on ICD-10 but also on the other more important systemic reforms that I discussed a few moments ago.

Athenahealth clients have no reason to fear. Because we are Internet based, we will throw a virtual switch at the moment ICD-10 requirement goes into effect, and every one of our clients will be upgraded at that same moment.

There is a solution to the perceived ICD-10 problem, and we certainly are not the only ones that can provide it. Repeated delays of supposedly firm deadlines both in ICD-10 and in other health IT programs like Meaningful Use make it all too easy for some in our industry to doubt future deadlines. Delays unintentionally create incentives for some vendors to forego the work necessary to prepare for ICD-10, confident that their failure to prepare will not harm their clients because we will continue to kick the can and not really move forward with reforms necessary to improve efficiency and patient care. This is a damaging cycle of nonperformance that will only be broken when the Government resolves to stick to the deadlines it communicates.

Either ICD-10 is worth doing or it is not. If it is, then stick to the deadline this year. There will be some disruption but our industry and the Nation's care providers will respond and adapt. If you conclude that the benefits of ICD-10 do not outweigh the potential risks, then cancel the program and focus legislation more aggressively on the few fundamental changes in health care that are necessary to cure our current dysfunctional system.

On behalf of Athena Health's 60,000-plus care provider clients and their many thousands of colleagues, I urge you in the strongest possible terms, do not again kick this can down the road. Pull the trigger or pull the plug.

Thank you.

[The prepared statement of Ms. Matus follows:]

Written Statement of Kristi A. Matus
Chief Financial and Administrative Officer
athenahealth, Inc.
House Energy and Commerce Committee, Health Subcommittee
Hearing: *"Examining ICD-10 Implementation"*
February 11, 2015

Summary of key points:

- ICD-10 should be implemented on October 1, 2015, the current deadline, or it should be canceled outright. No further delays in implementation should be imposed.
- Repeated delays in deadlines associated with key goals of our nation's ambitious, bipartisan healthcare agenda undermine the government's credibility and impede progress on crucial initiatives.
- ICD-10 is not a silver-bullet. But on the spectrum of needed systemic changes, it is a comparatively simple one—the technological equivalent of an upgrade from a relatively simple dictionary to a more complex one.
- We know that the switch to ICD-10 is possible. Much of the developed world has already successfully made the switch. Each of athenahealth's 60,000-plus care providers was ready before last year's deadline, and is ready today. Many other stakeholders are equally prepared.
- Repeated delays result in uncertainty, impose significant costs, create fear and stasis in the marketplace, and provide cover for unprepared vendors. This exacerbates future unpreparedness with regard to ICD-10 specifically, and the many other, more important changes necessary to improve technological sophistication in healthcare and transition from fee-for-service to value-based models.

Written Statement of Kristi A. Matus
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Full Statement

athenahealth, Inc. provides electronic health record (EHR), practice management, care coordination, patient communication, data analytics, and related services to physician practices, working with a network of more than 60,000 healthcare professionals who serve over 60 million patients in all 50 states. All of our providers access our services on the same instance of continuously-updated, cloud-based software. Our clients’ successes, exemplified by a Meaningful Use attestation rate more than double the national average and universal readiness for ICD-10 implementation, underscore the very real potential of health IT to improve care delivery and patient outcomes while increasing efficiency and reducing systemic costs. We appreciate the opportunity to share with the Subcommittee our perspective on ICD-10 implementation.

Based on our experience of partnering with medical practices to improve efficiency and outcomes, our point of view is simple: it is decision time. The federal government should maintain the current deadline for ICD-10 implementation, October 1, 2015, or cancel it, once and for all. Do not allow another delay.

Our nation has an extraordinarily ambitious, largely bipartisan healthcare agenda. From the effort to transition the nation’s care providers to modern technology via the Meaningful Use program and other incentives, to the clear imperative of shifting from the costly fee-for-service model to value-based delivery and payment structures, we have

Written Statement of Kristi A. Matus
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collectively resolved to tackle a series of very difficult, complex problems. All of these initiatives are animated by the over-arching goal of reducing costs and improving the quality and efficiency of patient care. To cite just one particularly timely example, the 21st Century Cures package of initiatives championed on a bipartisan basis by the Chairman and several Members of the Energy and Commerce Committee has tremendous potential to improve healthcare, but many of its components assume and depend upon continued technological evolution.

ICD-10 is by no means a silver-bullet solution to the many deficiencies of our current healthcare system, nor a panacea to address the specific imperatives described above. But on the spectrum of the challenges we face in healthcare, ICD-10 is a relatively easy one—the technological equivalent of an upgrade from a simple dictionary to a more complex one. Implementation will be orders of magnitude less difficult than achieving the changes in human behavior necessary for the Meaningful Use program to succeed, or achieving the fundamental evolution in healthcare business models necessary for truly accountable care. Repeatedly delaying the implementation of such a relatively simple change as ICD-10 calls into question whether we, as a country, are truly committed to improving healthcare, and potentially undermines the success of our national healthcare agenda by casting doubt on each subsequent goal and deadline the government sets.

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Fortunately, we know to a high degree of certainty that the ICD-10 switch is absolutely possible. Much of the developed world made the switch years ago, including, for example, the Czech Republic, Korea, and Thailand—where according to the World Bank the average annual healthcare spend per capita is 215 dollars, compared to nearly \$9,000 here in the United States. The ICD-10 code set was finalized in the early 1990s, at the very dawn of the consumer internet. ICD-9, still in use today in the United States, dates to the 1970s. There is simply no reason for the United States, a world leader in information technology outside of healthcare, should lag so conspicuously behind the rest of the developed world when it comes to our ability to track, document, and analyze the many millions of diagnoses made each day in this country.

More to the point, we know to a certainty that ICD-10 readiness is possible because we and others have achieved it. At athenahealth, we have already completed the work necessary to ensure that our clients were ready at last year’s deadline, as they will be ready at this year’s. We financially guarantee ICD-10 readiness for each of our tens of thousands of clients. And we are not the only solution. According to a 2014 survey by the ICD-10 Coalition, more than seventy five percent of the nation’s hospitals and health groups were ready for the transition last year. A Workgroup for Electronic Data Interchange (WEDI) September 2014 survey of 87 vendors indicated that two thirds of vendors have ICD-10 ready products available, roughly twice as many as in 2013.

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Many of our clients practice in exactly the kinds of small medical groups that have expressed significant concerns about the changes required to adapt ICD-10. Each new delay only multiplies the financial and emotional costs to such practices, which struggle not only with the implications of a possible code switch, but the persistent uncertainty created by repeated delays. Fear creates stasis, inhibiting progress not only on ICD-10, but also on the other more important systemic reforms referenced above, like the slow but steady transition to modern information technology, and the crucial shift from fee-for-service to value-based delivery and reimbursement models.

athenahealth's clients have no reason to fear. Because our services are internet-based, we will throw a virtual switch at the moment the ICD-10 requirement goes into effect and every one of our clients will be upgraded at that same moment. Our clients will not wait in implementation queues, nor will they face any degree of uncertainty about their readiness to meet the October 1 deadline. There is a solution to the perceived ICD-10 problem, and we certainly are not the only ones who can provide it.

Unfortunately, previous ICD-10 delays have exacerbated the unpreparedness that does continue to plague some of our nation's care providers, by affording cover to health IT vendors that, for whatever reason, have chosen not to prepare for implementation. Repeated delays of supposedly firm deadlines—both in ICD-10 and in other health IT programs, like Meaningful Use—make it all too easy for some in our industry to doubt

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future deadlines. Delays unintentionally create incentives for some vendors to forego the work necessary to prepare for ICD-10, confident that their failure to prepare will not ultimately harm their clients, or their own business interests, because the government will continue to kick the can and not really move forward with the reforms that improve efficiency and patient care. The WEDI vendor survey referenced above indicated that the most recent delay to 2015 negatively impacted provider readiness, causing two thirds of providers to delay their preparation efforts or place them on hold. This is a damaging cycle of non-performance that will only be broken when the government resolves to stick to the deadlines it communicates.

In summary, our position is simple: Either ICD-10 is worth doing, or it is not. If it is, then Congress and the Administration should enforce the October 1, 2015 deadline. There will be some disruption, but our industry and the nation's care providers will respond and adapt. Those who have not prepared for implementation will take the necessary steps to catch up to those who have.

If, however, Congress and the Administration conclude that the benefits of ICD-10 do not outweigh the potential risk of systemic disruption, then the program should be canceled outright, with subsequent regulation focused more aggressively on the few fundamental changes in healthcare that are necessary to cure our current dysfunctional system.

Written Statement of Kristi A. Matus
Chief Financial and Administrative Officer
athenahealth, Inc.
House Energy and Commerce Committee, Health Subcommittee
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February 11, 2015

On behalf of athenahealth's 60,000-plus care provider clients and their many thousands of colleagues we urge you in the strongest possible terms: do not again kick this can down the road. Pull the trigger or pull the plug.

We appreciate the opportunity to share our perspective on this important issue, and stand ready to respond to any follow-up questions or requests for additional information.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes Ms. Bocchino, 5 minutes for your opening statement.

STATEMENT OF CARMELLA BOCCHINO

Ms. BOCCHINO. Thank you. Good morning, Chairman Pitts and Ranking Member Green and members of the subcommittee. I am Carmella Bocchino, Executive Vice President of America's Health Insurance Plans, the trade association for the health insurance industry. I appreciate the opportunity to testify about the importance of implementing the ICD-10 system on October 1st without any further delay.

I think everyone here today agrees that we need more value in our Nation's healthcare dollar and we need a 21st century healthcare system. To support this goal, our members believe it is critically important for the healthcare system to move forward now with the ICD system to deliver greater value for consumers and improvements in quality improvement, and implementing ICD-10 under the current timetable will establish a strong foundation for allowing health plans and providers to identify and report conditions and medical treatments in more specific ways, ultimately leading to more effective measures of quality and health outcomes.

Delaying implementation will increase cost and impose significant administrative challenges across the entire healthcare system. Our industry processes millions of claims, eligibility requests, payments and other administrative and clinical transactions on a daily basis. Recognizing the migration to the ICD-10 code set has a major impact on all these activities. Our members have devoted a tremendous amount of time and resources to be ready by October 1, 2015. This includes extended outreach to healthcare providers as well as their vendors, working with them to provide education and implementation tools, crosswalks, practice management upgrades, and instructions and appropriate coding based on the provider's area of practice.

Our written testimony provides specific examples of steps many of our members are taking to prepare for ICD-10 implementation. For example, completed internal systems testing to assure successful use of ICD-10 on all claims and other transactions and engage with providers, hospitals and physician groups and their vendors to do this external testing, ensuring end-to-end testing of submitted claims. We have conducted readiness surveys to assess partners' familiarity with the coding system and the expected process for submitting compliant transactions and to see what support is continued to be needed, developed informational articles and resource materials that provide detailed information for healthcare providers on ICD-10 and how to incorporate the new coding system into their practices. They have updated clinical policies to reflect the new ICD-10 codes and provided this information to their healthcare provider partners. And some members have actually established a professional readiness portal for ICD-10 that allows hospitals, medical group systems, clearinghouses and individual providers to engage in testing and check their own readiness by submitting claims based on specific episode-of-care scenarios. These activities have been supplemented by significant efforts undertaken by HHS Road to 10 Initiative and private stakeholders as the

American Health Information Management Association, many professional societies and others.

From a quality improvement perspective, ICD code sets provide substantial more specificity and precision in defining a diagnosis or procedure. It will make it easier for healthcare providers and researchers to identify the correct code for a diagnosis or procedure and document medical applications. This expanded detail compared to the ICD-9 system is a fundamental building block for payment reform and will enable providers and payers to track health outcomes more effectively.

Because the ICD-10 system offers more granularity to identify disease, public health surveillance will be better equipped to analyze and interpret data, thereby providing early warning signals for impending public health emergencies, monitoring the epidemiology of public health problems, and informing public health policy.

In closing, I want to note that ICD-10 already has been delayed three times, as has already been stated. Another delay would bring significant cost and additional administrative challenges for health plans and providers that have been and are ready to implement, penalizing those who have invested the time and resources necessary to implement on time. Further delays also would prevent providers and payers from leveraging ICD-10 to improve patient care and quality outcomes.

Without the more accurate, reliable data that will be facilitated by ICD-10, ongoing efforts to a transition to a payment system based on quality and outcomes would not achieve their full potential. These outcomes both in terms of financial cost and lost opportunities are unacceptable.

For that reason, we strongly urge the committee to support the current schedule of implementing ICD-10 codes on October 1st.

[The prepared statement of Ms. Bocchino follows:]



Examining ICD-10 Implementation

by

**Carmella Bocchino
Executive Vice President
America's Health Insurance Plans**

**for the
House Energy and Commerce Committee
Subcommittee on Health**

February 11, 2015

I. Introduction

Chairman Pitts, Ranking Member Green, and members of the subcommittee, I am Carmella Bocchino, Executive Vice President at America's Health Insurance Plans (AHIP), which is the national association representing health insurance plans. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We appreciate this opportunity to testify regarding the implementation of the Tenth Revision of the International Classification of Diseases (ICD-10) system for diagnosis and procedure coding. Our members strongly support implementation of the ICD-10 system – beginning October 1, 2015 – without any further delay. It is critically important for the health care system to move forward with this new system under the current timetable. Doing so will establish a strong foundation for allowing health plans and health care providers to identify and report conditions and medical treatments in more specific ways, ultimately leading to more effective measurements of quality and health outcomes. Delaying implementation would increase costs and impose significant administrative challenges across the health care system.

Our testimony focuses on the following:

- The steps our members have taken, including partnering with physicians, hospitals, and other health care providers, to prepare for the launch of the ICD-10 system;
- The value of the ICD-10 system to health plans and health care providers and the role it will play in supporting quality improvement activities to advance health outcomes for consumers; and
- The importance of proceeding with full implementation of the ICD-10 system on October 1, 2015.

II. Health Plans Are Strongly Committed to ICD-10 Implementation

Our industry processes millions of claims, eligibility requests, payments, and other administrative and clinical transactions on a daily basis. The migration to the ICD-10 code sets

has a major impact on the business and administrative operations of health plans, and requires significant financial and human resources for successful implementation.

Health plans have devoted a tremendous amount of time and resources to be ready by the October 1, 2015 deadline for ICD-10 implementation. Our members' leadership on this issue clearly demonstrates that we are strongly committed to achieving a successful transition to ICD-10. In preparing for the launch of the new coding system, our members have been working closely with health care providers, other industry stakeholders, and the Department of Health and Human Services (HHS) on a wide range of activities to assure that ICD-10 implementation will be successful. In addition, plans have conducted extensive outreach to health care providers – both directly and in coordination with local and state medical societies – to provide ICD-10 education and implementation tools including ICD-9 to ICD-10 crosswalks, practice management system upgrades, and instruction in appropriate coding based on the provider's area of practice.

The following are several specific examples of how our members are addressing this priority:

- Aetna has been actively engaged in testing with business partners and has processed over 10,000 ICD-10 coded claims from physician groups and hospitals over the past two years. Additional testing has been scheduled for 2015. ICD-10 testing to date has been successfully completed with all vendor test partners with a variance of less than one percent on how clinical policies were applied for ICD-9 and a similarly coded ICD-10 claim. Aetna also has included articles about ICD-10 and the importance of provider readiness in each issue of its quarterly provider newsletter for the past several years, and has published webinars that outline the results from the first five cycles of its provider collaboration testing.
- Cigna completed a successful claim and pre-certification testing process to ensure its systems could accept ICD-10 codes and began testing with vendor partners in 2013. Cigna also provided its health care provider partners with frequent updates on ICD-10 implementation through newsletters, Frequently Asked Questions guidance, and meetings with physician office and hospital key staff. Additionally, Cigna has updated its clinical policies to reflect the new ICD-10 codes and provided this information to its health care provider partners.
- Humana has completed internal systems testing to assure successful use of ICD-10 on all claims and other transactions and engaged in external testing with facilities, including end-to-end testing of submitted claims. External testing with outpatient and professional practices was initiated in 2014 and continues to ensure all provider engagement. Education of

providers is also an important component to ensuring a successful transition to ICD-10, and therefore is a key element of Humana's engagement of providers in their networks.

- Independence Blue Cross and Blue Shield has developed a series of informational articles, *Putting ICD-10 into Practice: Coding Exercises and Scenarios*, and a coding resource book, *ICD-10 Spotlight: Know the Codes*, that provides detailed information for health care providers on ICD-10 and how to incorporate the new coding system into their practices.¹
- Regence Blue Cross' ICD-10 Professional Readiness Portal² allows hospitals, medical group systems, clearinghouses, and individual provider practices to engage in testing and check their readiness by submitting claims based on specific episode of care scenarios. In addition, as part of this process, Regence has built in a "feed-back loop" to report the results of testing and where improvements are needed.
- Blue Shield of California has conducted readiness surveys to assess trading partner familiarity with the ICD-10 coding system and the expected process for submitting compliant transactions on the implementation date. Through this process, existing ICD-9 claims from providers were compared to recoded claims using ICD-10 to identify gaps and determine if the claims were coded and reimbursed appropriately.³

These activities have been supplemented by significant efforts undertaken by HHS such as the Centers for Medicare & Medicaid Services' (CMS) "Road to 10" initiative and private stakeholders such as the American Health Information Management Association, the American Medical Association, and other interest groups.

Provider Outreach, Education, and Readiness

The Government Accountability Office (GAO) recently released a report⁴ outlining steps CMS is taking to prepare for the transition to ICD-10 on October 1, 2015. We are receiving very good reports about the effectiveness of the activities CMS is undertaking, including:

¹ Independence Blue Cross, "ICD-10 Resources," accessed at: http://www.ibx.com/providers/claims_and_billing/icd_10/index.html

² Regence Blue Cross, "ICD-10 Readiness and Testing Portals," accessed at:

<https://www.regence.com/documents/10192/34865/ICD-10+testing+flyer/cb55c99d-0314-4b08-98d5-d52cc7277c35>

³ Blue Shield of California, "Summary of Blue Shield of California's ICD-10 Testing to Date with Network Facilities, December 2014." Accessed at:

https://www.blueshieldca.com/provider/content_assets/documents/Announcements/BlueShield_TestingResults.pdf

⁴ Government Accountability Office, "International Classification of Diseases: CMS's Efforts to Prepare for the New Version of the Disease and Procedure Codes," January 2015. Accessed at: <http://www.gao.gov/products/GAO-15-255>

- holding in-person training for small physician practices in some states;
- completing all ICD-10-related changes to its Medicare fee-for-service (FFS) claims processing systems;
- providing technical assistance to Medicaid agencies and monitoring their readiness for the transition;
- scheduling end-to-end testing with 2,550 covered entities during three weeks in 2015 (in January, April, and July);
- promoting awareness of educational materials through partnerships with payers, providers, and others;
- engaging covered entities through bi-weekly stakeholder collaboration meetings and print advertisements; and
- conducting a direct mail pilot project for primary care practices in four states.

The GAO states that a majority of the stakeholders it contacted reported that the educational materials and outreach from CMS “have been helpful to preparing covered entities for the ICD-10 transition.”

In addition, a study⁵ recently published by *Perspectives in Health Information Management* suggests that physicians are receptive to using the ICD-10 codes and enthusiastic about the opportunities for quality improvement. The authors of this study state: “Most of the physicians we talked with were ready to embrace the change to ICD-10-CM/PCS and looked forward to ways in which they could mine new types of data that could help them with their patients and their practices.”

⁵ “Physicians’ Outlook on ICD-10-CM/PCS and Its Effect on Their Practice,” *Perspectives in Health Information Management*, Winter 2015, by Valerie Watzlaf, PhD, RHIA, FAHIMA; Zahraa Alkarwi, MS, HIS; Sandy Meyers, RHIA; and Patty Sheridan, MBA, RHIA, FAHIMA. Accessed at: <http://perspectives.ahima.org/physicians-outlook-on-icd-10-cmpcs-and-its-effect-on-their-practice/>

III. ICD-10 Implementation Will Support Quality Improvement Activities

The ICD is an internationally standardized diagnostic classification code set, maintained by the World Health Organization and used for studying the health and illness of populations, as well as for health management and clinical purposes, such as reimbursement, resource allocation, and improvements to health care quality. The ICD code set is periodically revised to allow for progress in the medical field. The ninth version (ICD-9) has been used in the United States since 1979 and is scheduled to be replaced by the tenth version (ICD-10) on October 1, 2015.

The ICD-10 system and the transition from the current ICD-9 coding procedures was developed over a period of many years, through a consensus building process that has included input from government agencies and stakeholders in the private sector, including representatives of the provider community, health plans, and vendors. Throughout this process, the use of ICD-10 codes has been guided by the recommendations of the National Committee on Vital and Health Statistics (NCVHS), an advisory commission that was established by Congress for the specific purpose of providing recommendations on health information policy and standards to the HHS Secretary.

The ICD-10 code sets provide substantially more specificity and precision in defining a diagnosis or procedure. For example, it allows clinicians to select separate codes depending on whether a patient is a Type 1 or Type 2 diabetic. This expanded detail, compared to the ICD-9 system, is a fundamental building block for payment reform. It will make it easier for health care providers and researchers to identify the correct code for a diagnosis or procedure, document medical complications, and track health care outcomes more effectively. This greater specificity, in turn, will support efforts to gain a deeper understanding of diseases, causes of death, and ways to make significant improvements in health care quality. In addition, ICD-10 adoption will facilitate efforts by health plans and other payers to develop pay-for-performance and other reforms necessary to achieve a more effective and efficient health care system.

The enhanced data that will be generated from the transition to ICD-10 will provide the U.S. health care system a wide variety of benefits. A white paper⁶ published by Highpoint Solutions identifies the following areas where ICD-10 is expected to contribute to improvements in health care quality and patient outcomes:

- Enhancements in our ability to measure and improve health care services: Implementation of ICD-10 will foster an environment where data generated through the new diagnosis and

⁶ "The Quality Benefits of ICD 10," John Wollman, HighPoint Solutions , July 27, 2011

procedure codes will be significantly more detailed, making it easier to measure the efficacy of health care services at a very granular level. Additionally, the author of the white paper notes that “the more specific diagnosis and procedure information in ICD-10 will support better correlation of the outcomes achieved from different medical processes, yielding much more actionable clinical outcome information and an improvement in care quality.”

- Improved support for disease management programs: Health plans have demonstrated strong leadership in pioneering disease management programs to meet the needs of patients with chronic conditions. These programs are directly linked to several factors that will be improved through the increased detail and specificity of ICD-10. These factors include the development of best practice protocols that lead to better outcomes, identification of patients who would benefit from disease management services, measuring adherence to health care and prescription drug protocols, and properly responding to changes in patient health.
- Enhanced ability to conduct public health surveillance: Public health surveillance relies heavily on the continuous, systematic collection, analysis, and interpretation of health-related data. Because the ICD-10 system offers a more granular ability to identify diseases, such surveillance will be better equipped to analyze and interpret data, thereby providing early warning for impending public health emergencies, monitoring the epidemiology of public health problems, and informing public health policy.
- Comparisons of health and morbidity data with other countries: The adoption of ICD-10 in the United States will improve the ability of researchers to compare international data on morbidity across approximately 100 nations and to identify new or evolving health threats on a global basis.
- Supporting a 21st century health care system: The ICD-10 system uses an alphanumeric structure, replacing the more limited numeric structure of ICD-9. This new structure will provide room for growth in diseases and procedure coding to support new treatments and technologies, replacing the current coding system that is rapidly becoming obsolete.

IV. ICD-10 Implementation Must Go Forward on October 1, 2015

Recognizing the potential for ICD-10 to support progress in quality improvement, we believe it is critically important to continue the momentum on this project and proceed with implementation on October 1, 2015.

Implementation of ICD-10 already has been delayed three times beyond the October 1, 2011 implementation date that originally was established by an HHS proposed rule published in 2008.

In 2010, prior to the last implementation delay, our members reported that ICD-10 implementation was expected to cost health plans in the range of \$2 to \$3 billion.⁷ Each delay brings significant costs and additional administrative challenges for health plans and providers that are ready for implementation – penalizing those who have invested the time and resources necessary to implement on time. Further delays will also prevent providers and payers from leveraging ICD-10 to improve patient care and quality outcomes.

Health plans and health care providers will have to interrupt ongoing training, operational, and testing programs, and resources dedicated to these efforts will have been wasted. Plans and providers also will have to dedicate additional resources to “undo” information technology and administrative system changes that already have been made in anticipation of the October 1, 2015 implementation deadline. For example, health plans have established extensive information technology systems that will automatically change over coding, claims payment, and other processes on the transition date.

These concerns – which also were raised prior to last year’s delay – were highlighted by the NCVHS in a September 2014 letter⁸ addressed to HHS Secretary Sylvia Burwell, which recommended that “HHS and industry leaders should proactively emphasize to Congress the merits of ICD-10, progress made by the health care industry in its readiness to implement ICD-10, and, costs to the health care industry associated with any further delay.” In this same letter, NCVHS noted that witnesses at a June 2014 NCVHS hearing cautioned that “another delay in implementing ICD-10 would add to the already substantial costs of delays arising from stopping and re-starting processes and re-education and training of staff.”

It is crucial to send a clear signal that implementation will proceed on October 1, 2015. This certainty is needed to avoid another scenario – which occurred following the last implementation delay – in which many health care providers stop implementation activities and testing, and health plans and providers face significant disruptions in longstanding information technology and administrative systems projects dedicated to ICD-10 implementation.

⁷ America’s Health Insurance Plans, “Health Plans’ Estimated Costs of Implementing ICD-10 Diagnosis Coding, September 2010.”

⁸ NCVHS letter to HHS Secretary Sylvia M. Burwell, September 23, 2014. Accessed at: <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/10/140923lt2.pdf>

From a quality improvement perspective, we are concerned that another delay will impact initiatives that are replacing volume-based payments with value-based payments. Without the more accurate and reliable data that will be facilitated by ICD-10, ongoing efforts to transition to a payment system based on quality and outcomes will not achieve their full potential. Additional benefits from adoption of ICD-10 – including better disease management, public health monitoring, and the ability to track new medical procedures and devices – will be unnecessarily delayed.

We also strongly oppose any efforts to make a partial change to ICD-10 codes that will phase in different provider groups or different codes over time – for example, making the transition for hospitals on one date and for physician practices on a later deadline or adopting diagnosis codes and procedure codes on different dates. Among other costs, this would impose dual tracking of claims systems for both public and private payers and the need to develop hybrid DRG definitions (utilizing ICD-9 and ICD-10 codes).

Finally, we believe it would be a serious mistake, as some have suggested, for policymakers to bypass the ICD-10 system altogether and wait until the ICD-11 system is ready. This misguided approach would force our health care system to continue to use, possibly for another 20 years or longer, an outdated code set that is not equipped to account for new developments in medical technology or the next generation of diagnoses and procedures. This approach also fails to recognize that ICD-10 will serve as a foundation for ICD-11. A commentary⁹ recently posted by the Coalition for ICD-10 explains: “ICD-11 is built on ICD-10 and benefits from the clinical knowledge and additional detail that have been incorporated into the U.S. version of ICD-10. Transitioning to ICD-10 in 2015 will provide an easier and smoother transition to ICD-11 at some point in the future.”

V. Conclusion

Thank you for considering our views on the importance of proceeding with the implementation of the ICD-10 codes on October 1, 2015. We stand ready to work with the committee to address any additional questions or issues that may arise in the months leading up to the launch of this important system.

⁹ “Commentary: Waiting for ICD-11,” Coalition for ICD-10, (<http://coalitionforicd10.org/2015/01/13/waiting-for-icd11/>), January 13, 2015

Mr. PITTS. The Chair thanks the gentlelady and now recognizes Dr. Terry, 5 minutes for your summary.

STATEMENT OF WILLIAM JEFFERSON TERRY, SR.

Dr. TERRY. Chairman Pitts, Ranking Member Green, members of the subcommittee, my name is Dr. Jeff Terry, and I am testifying today as a member of the American Urological Association and as a practicing urologist who puts in 13 hours a day taking care of patients in Mobile, Alabama. We thank you for this hearing very much.

The AUA has a membership of 18,000 physicians and is also a member of the Alliance of Specialty Medicine. During the last Congress, I had the privilege of moderating an Alliance roundtable on ICD-10 where members of CMS were actually present.

The AUA enters this debate on ICD-10 as an advocate for the patients and the physicians. As you hear testimony today, keep in mind the concerns of practicing physicians who want to preserve the all-important patient-physician relationship and don't put the computer and statistics in the middle of this relationship.

I know that you will weigh any proven patient care advantages of ICD-10 against the consequences of a flawed implementation. Ultimately, the benefits should outweigh the risks.

The ICD system was designed for the purposes of gathering statistical and epidemiological data. The United States is the only country that uses it as part of the billing system. ICD-10 is planned to replace ICD-9 all in one day. Our present system has 13,000 codes where ICD-10 will have anywhere between 68,000 and 87,000 codes, and the United States is the only country that uses all of these codes. The other countries use about a fifth of that number. Experts estimate physicians should plan on a 3 to 4 percent increase in time per patient encounter merely to document the correct code. The coding guidelines for ICD-10 are more complex, and those who do not fully understand them will fail to document correctly and not be paid.

Proponents of ICD-10 say the increased specificity will improve clinical data and improve quality. These potential benefits are not documented. However, the cost of ICD-10 is well documented for physicians who already face increased cost in complying with EHR incentive programs, the PQRS Quality program, the Value-Based Payment Modifier Program, not to mention the annual threat of SGR cuts and the 2 percent sequestration cut that we already have.

Now we are faced with the costly unfunded mandate of ICD-10 that will certainly put some physicians out of business. Physicians are overwhelmed with the tsunami of regulations that have significantly increased the work for our practices. Physicians are retiring early, which could leave countless number of patients without a doctor. Based on data in other countries, all physicians will be forced to reduce the number of patients that they see when ICD-10 is implemented, which can last for more than a year, resulting in less efficient practices and making it difficult for patients to get the care they need.

An independent study last year found significant cost associated with upgrading the hardware, the software, the training of per-

sonnel and the conversion of ICD-10 ranging from \$50,000 to \$250,000 for small practices and several million dollars for large practices. CMS states that physicians consider getting a line of credit to cover cash-flow problems and expenses. Others have suggested the need for a 3- to 6-month cushion. This is not possible for most practices that have very few assets to quality for these significant loans.

While CMS is in the midst of end-to-end testing, it is primarily being conducted by volunteers who are prepared. We worry that these results do not paint an accurate picture of the current state of provider readiness.

Ladies and gentlemen, no matter what the coalition or the coding industry says, the vast majority of America's physicians in private practice are not prepared for this ICD implementation all in one day. The continual threat of Medicare payment reductions, the time-consuming CMS quality programs, the new EHR systems, Medicare compliance programs occupy physicians so much that they don't have the time or resources to prepare for ICD-10. It is harder and harder to keep the patient as the primary focus in our daily activities. ICD-10 is viewed as another expensive distraction with little demonstrated value to improving patient care. The huge costs certainly outweigh the very few benefits as far as patient care is concerned.

Our focus today is not centered solely on the financial investment made by large health insurers, health systems and other entities preparing for this transition. Our focus is about our Government providing an environment where physicians and healthcare professionals can devote all of their energies to medical issues for the benefit of their patients. To that end, I urge Congress to delay implementation of ICD-10 and appoint a committee to better study the risks and the benefits with the patient in mind. If a delay is not possible, then consider a dual ICD-10 option permitting physicians to make the transition so we can survive in our practices.

Thank you so much for your commitment and your leadership on this issue. ICD-11 is probably 5 years away so we need a policy for appropriate coding transitions in order to avoid this problem again.

I am happy to answer any questions that you see fit.

[The prepared statement of Dr. Terry follows:]¹

¹Additional material submitted by Dr. Terry has been retained in committee files and also is available at <http://docs.house.gov/meetings/IF/IF14/20150211/102940/HHRG-114-IF14-Wstate-TerryW-20150211-SD001.pdf>.

William Jefferson Terry Sr, M.D.

on behalf of the

American Urological Association

Written Testimony for the Record

Before the House Energy and Commerce Subcommittee on Health

Hearing Entitled

“Examining ICD-10 Implementation”

Wednesday, February 11, 2015

Chairman Pitts, Ranking Member Green, members of the Subcommittee on Health, and honored guests, my name is Dr. William Jefferson Terry and I am testifying in front of you today as a member of the American Urological Association and as a practicing urologist in Mobile, Alabama at Urology & Oncology Specialists, PC. The AUA would like to thank the House Energy and Commerce Subcommittee on Health for taking an in-depth look at the implementation of ICD-10. The AUA appreciates the opportunity to share our views related to the health care classification system of diagnostic codes, including the administrative and financial burden, implementation preparation, and overall uncertainty about the impact ICD-10 will have on the practice of medicine.

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For your reference, the AUA was founded in 1902 and is the premier professional association for the advancement of urologic patient care. The AUA works to ensure that its more than 18,000 members are current on the latest research and practices in urology. The AUA also pursues its mission of fostering the highest standards of urologic care by providing a wide range of services—including publications, research, the Annual Meeting, continuing medical education (CME) and the formulation of health policy. The AUA is a member organization of the Alliance of Specialty Medicine, and last Congress I moderated an Alliance physician roundtable which included representatives from the Centers for Medicare and Medicaid Service (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) on the subject of ICD-10 implementation due to concerns by many physician organizations regarding this matter.

The AUA enters the debate on ICD-10 as an advocate for patients and physicians. Our organization and its members are vested in the preservation of the all-important patient-physician relationship. From a personal standpoint, I have a son who is a physician. In addition, I have recently entered the medical system as a cancer patient, and I worry about the impact of ICD-10 on my cancer care providers, as I do not want to see them retire early from the medical profession out of frustration.

As you hear testimony today from each of the witnesses, I hope that you will keep in mind the concerns of practicing physicians – particularly those in small practices – balanced with *proven* advantages of ICD-10 on direct patient care and weighed against the consequences of a poorly executed implementation. This is what I always discuss with my patients when sharing in the decision on various treatment options; “Do the benefits outweigh the risks?”

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The International Classification of Diseases (ICD) is designed to promote international comparability in the collection, processing, classification, and presentation of mortality statistics, and for the purpose of gathering statistical and epidemiological data. ICD provides a system of diagnostic codes for classifying diseases, including nuanced classifications of a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. The ICD Clinical Modification 9th revision (ICD-9-CM) is a unique system for use specifically in the United States. ICD-9-CM Volumes 1 and 2 are used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office utilization, whereas Volume 3 is used in assigning codes associated with inpatient procedures. The United States is the only country in the world that has modified the classification system for use in payment and reimbursement programs. Physicians and other outpatient facilities use the American Medical Association's (AMA) Current Procedural Terminology (CPT) to report outpatient procedures, such as doctor's office visits and other professional health care services. The CPT system is actually designed for and used to submit the physician's bill for services.

ICD-10-CM is the clinical modification (CM) to the 10th revision of the ICD classification system. ICD-10 has been used in the United States for reporting of mortality since January 1, 1999, and its clinical modification, ICD-10-CM, is planned as the replacement for ICD-9-CM, volumes 1 and 2 beginning October 1, 2015. On this date, physicians will be required to use the new code set to report diagnoses, but will continue to use CPT to report professional services.

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Our present ICD-9 system has approximately 13,000 codes whereas ICD-10-CM has 68,000 codes. The United States is the only country to use all 68,000 codes, whereas most countries use only about one fifth the number of codes. We are hopeful that most physician practices will only be required to use a relatively small proportion of the diagnostic code set, but that remains to be seen.

There are significant differences between the current ICD-9-CM and the new ICD-10-CM classification system. ICD-9 codes are mostly numeric and have 3 to 5 digits. ICD-10 codes are alphanumeric and contain 3 to 7 characters. ICD-10 is significantly more descriptive with one-to-many matches in many instances.

ICD-9-CM is considered to be outdated because its structure is limited, it lacks specificity and there is no more room to add new diagnosis codes in certain areas. ICD-10-CM will increase specificity, allow for reporting of laterality and provide a new coding system with new rules for reporting diagnosis coding. Some diagnosis codes will have one to one correlation between ICD-9-CM to ICD-10-CM, where others will have a one-to-many correlation. In addition, there are quite a few areas that have been expanded to report right vs. left, unilateral vs. bilateral, male vs. female, as well as etiology, severity and anatomic location. There is also a new requirement to report whether the encounter is initial, subsequent, or a sequelae and the cause of the condition.

The AUA worked with key stakeholders, including the National Centers for Health Statistics of the Centers for Disease Control and Prevention (CDC), to capture urologic diagnosis

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codes that were either inaccurate or lacking from the initial ICD-10-CM classification system. More than 10 sections of the new code set required additional revisions. Unfortunately, these important revisions will not take effect until October 1, 2016, one year after the current implementation deadline. The AUA appreciated the opportunity to work with agency staff to address those issues.

It is estimated that physicians should plan on a 3-4 percent increased time (average) per patient encounter merely for documentation of the correct ICD-10 code choice. While there will be no foreseeable change for many patients, for others there could be a significant amount of time documenting and choosing codes. There are 250 codes just for Diabetes alone. Those who best understand ICD-10 and who are most prepared will see the lesser end of this increase, while those unprepared will have a tremendous stress placed upon them and their practices.

The main reason for the reduced productivity lies in the fact that ICD-10 is significantly more granular, requiring enhanced documentation. In addition, the coding guidelines associated with the new system are more complex. Physicians will need to be much more specific when documenting etiology (of certain conditions), laterality (of certain conditions), location of the process (certain conditions), visit number (initial, subsequent, or sequelae of the condition mainly for trauma and external injury), among other items. There are also exclusions and sequencing rules that need to be understood. Physicians need to understand the ICD-10 coding construct for successful code choice. Those who do not understand will fail to document correctly, making it more difficult to code correctly, thus delaying or preventing appropriate and timely reimbursement.

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Proponents of the ICD-10 transition tout the classification system's increased granularity as a benefit. That is, improved clinical data will lead to better-informed clinical decisions and improved clinical quality. These potential benefits have not been founded in any recognized medical literature or research study. However, the costs of the conversion have been studied and well-documented, and are a major issue for physicians and their staff who are already facing tremendous pressure to comply with a myriad of complex federally-driven initiatives, such as the Electronic Health Record (EHR) Incentive Program, the Physician Quality Reporting System (PQRS) program, the Value-based Payment Modifier (VM), not to mention the annual threat of reimbursement cuts due to the flawed Sustainable Growth Rate (SGR) formula, the 2% sequestration cuts, and CMS' other programs, including multiple audit programs. And, now we face a very costly, unfunded mandate in moving to ICD-10.

Physicians are overwhelmed with the tsunami of regulations that have significantly increased the volume of work for physicians and their staff, many of which have questionable value to improving the quality of care provided to patients. Many physician practices (especially the rural one- or two-physician practices) do not have the time, money, or expertise to follow and comply with the mounting regulatory challenges, which is why many are considering early retirement or opting out of the Medicare program. Given current physician workforce and staffing challenges, this is an important consideration. Should physicians leave the medical professional due to the increased financial and administrative burdens imposed by the federal government, countless numbers of patients could be left without a provider. Even for practices who sustain the implementation, they may be forced to reduce their clinical schedules during the

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transition period, making it difficult for patients to access and receive important medical care.

Over the past several years, the AUA has worked diligently to educate its members on the move to ICD-10, developing tools to help urologists manage the task ahead, while also assisting them with other practice management issues. CMS and other coding-focused entities have also developed tools and educational materials to help ease learning and lessen the burden of the forthcoming transition, however, these tools are not enough to help most convert to the new system by October 1, 2015. In fact, most of them have been designed with primary care practices in mind, with very little being available for specialty practices like mine. In addition, CMS' General Equivalence Mappings (GEMs), which map ICD-9 to ICD-10 codes, are not a direct "cross-walk" between the two classification systems. This means urologists and their staff will have to learn the new system from the "ground up." Learning a new coding system, even for our most adept physicians and knowledgeable coding and billing staff, is a significant and burdensome challenge.

CMS and the coding industry have said that it can take a year to adequately prepare for this transition. If we must transition, ICD-10 implementation should be incremental – carried out over 2-3 years, which we believe CMS and other health insurers' administrative systems are capable of. In fact, all insurers will run dual-systems for some time period given the lag between when claims must be filed and processed. A hastily implemented transition could prompt serious unintended consequences and be detrimental for all stakeholders, including patients.

I also have serious concerns with the potential cash flow nightmare that physicians will

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face while transitioning to ICD-10. There are significant costs associated with upgrading hardware, software, and training personnel for the massive conversion to ICD-10. An independent study by Nachimson Advisors one year ago showed the cost of conversion to small practices could range from \$50,000 to \$250,000 depending on the charges from various system vendors coupled with lost productivity and potential denied claims. This figure for larger practices of 100 physicians or more can vary from \$2 – 8 million.¹

ICD-10 implementation consultants as well as CMS have also recommended that practices reserve enough money to cover medical supplies, payroll, rent, and everything else required to keep the practice operational for three to six months. That will be especially difficult for small practices that may not have the funds on hand and will need to work with a bank to secure loans. My urology practice of 8 physicians needs close to \$800,000 to run each month and my banker will not give me a line of credit for 3 - 6 months because it would be an unsecured line of credit. Since we rent our office and own very little, if we did go out of business after 1 – 2 months it is more than likely that the bank could not be repaid.

While the reduction in cash flow will be most pronounced for those who are least prepared, it will still affect those who are well prepared, albeit less. There are many steps involved between when a physician provides a service and when he gets paid. The physician can document and code perfectly, however, if anything goes wrong in what I refer to as the massive “payment pyramid” the physician could potentially go unreimbursed for care provided. In fact,

¹ “The Cost of Implementing ICD-10 for Physician Practices -- Updating the 2008 Nachimson Advisors Study”, A Report to the American Medical Association, Nachimson Advisors, LLC, February 12, 2014.

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while ICD-10 proponents tell us that the new system has the potential to make payment more precise, given the more robust and accurate documentation of services, the expense in doing so will likely result in higher costs to the physician practice, as well as payers and patients. We also worry that providers who aren't as skilled and rigorous in documenting services under ICD-10 will receive lower payments.

CMS admits that, "Lack of reimbursement could force practices to shut down, making medical services inaccessible to patients and/or forcing physicians to ask patients to pay up front, out-of-pocket, for medical services, which, aside from being barred by the terms of some insurance programs, would be extraordinarily burdensome to patients."²

Those who believe that ICD-10 is merely an expansion of ICD-9, or those who believe that they can just search for a code on their EHR or with a search tool will be the ones who will be most affected. Those who believe that they will just use the "unspecified" codes for each condition will be the ones with the most delays in payment, request for records, and denials. By looking at the ICD-10 code set, I see very rare cases where "unspecified" codes can be correctly used in ICD-10, as the coding system is so comprehensive. I could see a situation where "unspecified" codes are denied outright and records are requested by payers to see if the patient truly warranted an "unspecified" code, or if the provider merely didn't take the time to learn the specificity needed to code correctly and chose the "unspecified" code out of convenience or lack of education. CMS says that after ICD-10 implementation, physicians can expect changes in

² "A Change to the Compliance Date for ICD-10-CM and ICD-10-PCS Medical Data Code Sets, Proposed Rule." Federal Register 77:74 (17 April 2012) p. 22989.

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payers' prior authorizations and approvals as they refine medical policies. Physicians may also see a significant increase in denials as a result of coding challenges. Audits of all types will increase in depth and breadth, including Recovery Audits. After the transition to ICD-10, the specificity and detailed information levels will result in greater documentation scrutiny. This means the physician is less likely to be paid for services provided to patients.³

We are also concerned with the limited amount of testing to determine industry readiness. CMS is in the midst of conducting "end-to-end" testing with physicians, but it will not be completed until a few short weeks before the October 1 deadline. In addition, and given testing is primarily being conducted by volunteers, we also worry the results will not paint an accurate picture of the current state of provider readiness. A survey conducted by the Medical Group Management Association (MGMA) found less than 10 percent of practices have made significant progress to prepare for the transition. It is my sense that practices that volunteer are more likely to be prepared, and will not be reflective of the broader physician community. CMS must release the results of its ICD-10 testing activities and practice demographics for its volunteers, including practice and staffing size, specialty, and health system affiliations. CMS should also reveal details of its contingency plan, given the strong possibility that many providers will not be ready to make the transition on October 1.

No EHR system, professional coder/biller or online ICD-10 search tool can prepare any physician for the massive change in moving from ICD-9 to ICD-10. A successful transition will take a tremendous amount of work related to EHRs, practice management, clearinghouses,

³ "ICD-10 Implementation Guide for Small and Medium Practices", CMS 2012

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payers, provider education, coder/biller education, changing super bills, changing documentation patterns, and understanding the nuances of ICD-10.

Simply put, physicians are not prepared for this change. Given the annual threat of reductions in Medicare reimbursements, the burden of participating in multiple CMS quality improvement programs and adopting health information technologies to avoid steep financial penalties, and the expense of ensuring compliance with Medicare's ever changing requirements and multiple audit programs, physicians and their staff simply do not have the time to focus on transitioning to ICD-10. Physicians are growing exhausted; ICD-10 is just another expensive distraction with little demonstrated value to improving direct patient care.

Studies showed that 25% of hospitals and health systems were not confident in their ability to implement ICD-10 just prior to the last delay. If we assume a conservative estimate, suggesting that 10% of physicians will not survive the implementation, that means thousands of patients will have to find a new doctor, an already challenging task given current workforce and staffing issues.

Our focus today should not be centered solely on the financial investment made by large health insurers, health systems, and other entities on preparing for this transition. Rather, we should be honing all of our collective efforts to improve the quality and value of healthcare in this country. To accomplish this, the federal government should promote and enable a practice environment where physicians and other healthcare professionals can devote all of their energies on direct patient care, achieving a healthy America without undue burden and distraction.

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To that end, I urge Congress to delay implementation of the ICD-10 code set and appoint a committee to better study the “risks and benefits.” If a delay is not possible, I urge you to consider legislating a dual ICD-9/ICD-10 option so that physicians will have time to transition to the new coding system especially those nearing retirement or those with a demonstrable hardship that limits their ability to adopt ICD-10 by the deadline.

Thank you for your commitment and leadership on this important issue to urologists and my colleagues in medicine. It is important to urologists and the medical profession, and it is important to all patients not to lose their physicians from a government mandate that is not well thought out. ICD-11 is at least 5 years away so we need a policy for appropriate coding transitions in order to avoid this problem again in the future. I am happy to answer any questions or follow up with additional information about the challenge ICD-10 poses to the practice of medicine.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Dr. Hughes, 5 minutes for your opening statement.

STATEMENT OF JOHN S. HUGHES

Dr. HUGHES. Thank you, sir. Mr. Chairman and members of the committee, first let me just interject that I very respectfully appreciate Dr. Terry's comments about the stresses of the regulatory burden placed on physicians, but I would offer that ICD-10 is not the major problem and is probably a trivial problem compared to the other issues that confront practices today.

I am a general internist. I am Professor of Medicine. I teach medical students and medical residents. I see patients on my own and I conduct research in areas of quality assurance.

One of the research areas I have focused on is the study of complications of care, with the view that if we can accurately identify the factors and circumstances that account for complications, then we will be able to reduce their occurrence. In fact, several States, Maryland for one, are now adjusting hospital payments based on some of this research.

The usefulness and reliability of this kind of research depends very much on how precisely we can identify the specifics of the complication and exactly how they are treated. Although we have made considerable progress in addressing complications, other quality issues in the past several years, complication rates remain unacceptably high. The ICD-9 coding system fails to provide the level of detail needed to expand these efforts. I have been personally frustrated many times at ICD-9's inability to specify the exact nature of a complication, its extent, its location, and how it was treated.

Now, as an example, let me ask you to consider a 74-year-old man who fell, sustaining a puncture wound that severed his left femoral artery. He was rushed to surgery, where the damaged portion of the artery was replaced with a synthetic graft. These events are coded in ICD-9 as a diagnosis of "injury to the common femoral artery" and the procedure code is "resection of vessel with replacement." There is no mention that the injury was a major laceration on the left side, or that the type of replacement was a synthetic graft, all of which is included in the ICD-1.

This lack of detail is even more obvious when it comes to complications. Consider the same man developed bleeding at the site of the graft on the day after surgery. He was returned to the operating room, his incision was reopened and the graft repaired at the site of the leak. ICD-9 codes this as "mechanical complication of other vascular device or implant or graft" and the procedure code is "revision of vascular procedure." So all we know is that there has been some type of complication that required some type of surgery, and that is about it. The ICD-10 code provides a much more complete picture, telling us that the complication was a hemorrhage, exactly where it occurred, and that the revision was a re-suture of the graft using an open approach. This is but one example. There are numerous throughout the ICD-9 system, and the benefits of the ICD-10 providing the extra detail.

Another major flaw in ICD-9 is that it does not have the capacity to expand to provide new codes describing new treatments and

technologies. This means that new techniques such as minimally invasive surgery, which have been increasingly and successfully used in cardiac surgery, and are rapidly expanding into other surgical fields, cannot be adequately described using the simplistic four-digit and sometimes five-digit structure of ICD-9. Minimally invasive surgeries use smaller incisions, which results in fewer complications, less discomfort, more rapid healing and shorter hospital stays.

Now, we don't need ICD-10 in order to do minimally invasive surgery but these new procedures will not be adequately described if we continue to use ICD-9. They will have to be described in general terms or they will have to be included in codes that contain open surgical approaches, resulting in insufficient detail to track their increasing use.

The structure of ICD-10 allows this important information to be captured in a systematic manner, and can be readily expanded to incorporate descriptions of new discoveries and treatments when they become available. This capacity is critical to track and assess the efficacy of these new technologies.

Thank you very much.

[The prepared statement of Dr. Hughes follows:]

February 11, 2015, Committee on Energy and Commerce

Testimony of John S. Hughes, M.D.

Professor of Medicine, Yale School of Medicine

I am a general internist and Professor of Medicine at Yale School of Medicine. One of the research areas I have focused on is the study of complications of care, with the view that if we can accurately identify the factors and circumstances that account for complications then we will be able to reduce their occurrence. Indeed, several states such as Maryland are now adjusting hospital payments based on this research.

The usefulness and reliability of this kind of research depends very much on how precisely we can identify the specifics of the complication and exactly how it was treated. Although considerable progress has been made in the past several years, complication rates remain unacceptably high. The ICD-9 coding system fails to provide the level of detail needed to expand these efforts. I have been frustrated many times at ICD-9's inability to specify the exact nature of a complication, its extent, its location, and how it was treated.

As an example of the differences between ICD-9 and ICD-10, consider a 74-year-old man who fell, sustaining a puncture wound that severed his left femoral artery. He was rushed to surgery, where the damaged portion of the artery was replaced with a synthetic graft. These events are coded in ICD-9 as a diagnosis of “Injury to the common femoral artery”, and a procedure of “Resection of vessel with replacement”. There is no mention that the injury was a major laceration on the left side, or that the *type* of replacement was a synthetic graft, all of which is included in the ICD-10 coding.

The lack of detail is even more obvious when it comes to complications. The same man developed bleeding at the site of the graft on the day after surgery. He returned to the OR, his incision was reopened and the graft repaired at the site of the leak. ICD-9 codes this as “Mechanical complication of other vascular device or implant or graft” and the procedure code is “Revision of vascular procedure”. So all we know is that there has been some type of complication that required some type

of surgery, but that's about it. The ICD-10 code provides a much more complete picture, telling us that the complication was a hemorrhage, exactly where it occurred, and that the "revision" was a re-suture of the graft using an open approach.

Another major flaw in ICD-9 is that it does not have the capacity to expand to provide new codes describing new treatments and technologies. This means that new techniques such as minimally invasive surgery, which have been increasingly and successfully used in cardiac surgery, and are rapidly expanding into other surgical fields, cannot not be adequately described using the simplistic four digit structure of ICD-9. Minimally invasive surgeries use smaller incisions, which results in fewer complications, less discomfort, more rapid healing and shorter hospital stays. If we continue to use ICD-9, these new procedures will have to be described in general terms or included in codes that contain open surgical approaches, resulting in insufficient detail to track their increasing use.

The structure of ICD-10 allows this important information to be captured in a systematic manner, and can be readily expanded to incorporate descriptions of new discoveries and treatments when they become available. Such capacity is critical to track and assess the efficacy of these new technologies.

Mr. PITTS. The Chair thanks the gentleman. Thank you all for that excellent testimony. I will begin the questioning and recognize myself for 5 minutes for that purpose.

I would like to ask a series of questions to all of you, so please respond yes or no to these, and we will just go down the line. We will start with you, Dr. Burke.

In your opinion, do you believe we are ready for ICD-10 implementation, yes or no?

Dr. BURKE. Yes.

Mr. PITTS. Mr. Averill?

Mr. AVERILL. Yes.

Mr. PITTS. Ms. Bowman?

Ms. BOWMAN. Yes.

Mr. PITTS. Ms. Matus?

Ms. MATUS. Yes.

Mr. PITTS. Ms. Bocchino?

Ms. BOCCHINO. Yes.

Mr. PITTS. Dr. Terry?

Dr. TERRY. No.

Mr. PITTS. Dr. Hughes?

Dr. HUGHES. Yes, sir.

Mr. PITTS. All right. Thank you. Again, all of you, in your opinion, should Congress oppose attempts to delay ICD-10 implementation? Dr. Burke?

Dr. BURKE. No.

Mr. AVERILL. It was a double negative.

Mr. PITTS. Let me repeat the question. In your opinion, should Congress oppose attempts to delay ICD-10 implementation?

Mr. AVERILL. They should oppose.

Mr. PITTS. Yes. OK.

Ms. Bowman?

Ms. BOWMAN. Yes.

Mr. PITTS. Ms. Matus?

Ms. MATUS. Yes.

Mr. PITTS. Mrs. Bocchino?

Ms. BOCCHINO. Yes.

Mr. PITTS. Dr. Terry?

Dr. TERRY. No, sir.

Mr. PITTS. Dr. Hughes?

Dr. HUGHES. Yes.

Mr. PITTS. All right. Again, down the line, Dr. Burke, we will start with you. In your opinion, what impact would delay have on your industry and the patients you serve? You can elaborate a little bit.

Dr. BURKE. Well, I think, you know, the ICD-10 is a very good communication tool. Either you can use the ICD-10 code or you would have to use it in your plan. You would have to type out everything in your plan, so actually it flows a lot more smoothly.

Mr. PITTS. OK. What impact would delay have on your industry or patients you serve, Mr. Averill?

Mr. AVERILL. Well, certainly it would dramatically increase the cost of being prepared to ultimately move forward. It would also continue to compromise our national data in terms of having the necessary information to evaluate many of the things that the

panel talked about, and so what is most concerning to me is the dramatic increase in cost of any delay.

Mr. PITTS. Mrs. Bowman?

Ms. BOWMAN. I would say certainly the cost. Our members are health management professionals who have been trained and re-trained and have to keep their training updated to maintain their skills for whenever ICD-10 is implemented so the cost and also I would agree with Rich's comment about the delay and being able to use the better delay.

Mr. PITTS. Mrs. Matus?

Ms. MATUS. Countless care providers, hospitals and other institutions have already put untold thousands of dollars into preparing for ICD-10, so those are the hard costs. The soft costs of, you know, the uncertainty which is magnified by each delay is unquantifiable.

Mr. PITTS. Mrs. Bocchino?

Ms. BOCCHINO. So I will echo what others have said but I will also add that a lot of times additional documentation is required by providers under ICD-9 in order to process a claim. Because of the specificity of the ICD-10 codes, much of that documentation will go away and therefore we believe it will actually reduce some of the burden on providers.

Mr. PITTS. Dr. Terry?

Dr. TERRY. I know I am in the minority on this panel but I want you to know, I represent thousands of doctors. Speaker Boehner has four boxes of thousands of letters in his office on this subject. I have some at the table.

You know where I stand. It has the potential to do irreparable harm to the patients and the physicians who can't implement this the way industry wants us to. You know, we don't treat by statistics. I mean, this is just something that gets in our way of taking care of our patients, and it has to be done the right way.

Mr. PITTS. All right. Dr. Hughes, what impact would delay have on your industry or patients you serve?

Dr. HUGHES. I agree that this has to be done in the right way. Delay means a couple things. One, if physicians are interested in keeping up with what is happening and learning the effectiveness of new treatments, we need to have better data. So that will—if we don't implement this, we are not going to be having the optimum amount of data.

Mr. PITTS. All right. We are going to have to keep going. I have a couple more questions.

Dr. Burke, does ICD-10 bring any value to the patient community? It is one thing to improve systems operations for insurers and hospitals but how does this matter to patients?

Dr. BURKE. I think, you know, for instance, if you use an ICD-9 code and a patient calls a couple days later, like if they come in with leg pain, you know which leg it is. You will have to ask them again where their pain was, but if you use an ICD-10 code, you can actually localize the pain to either extremity. So it is a lot better communication tool.

Mr. PITTS. Now, we heard a little bit mentioned about ICD-11. Ms. Matus, what are your thoughts on, you know, just wait for it instead of forcing people to go through ICD-10?

Ms. MATUS. So, you know, again, we think this is either important to do or it is not. If we were convinced that the United States that we as a group would take a leadership position in moving forward with ICD-11, then maybe miss ICD-10. But without a firm commitment to be the leaders in a new coding methodology that is still 5 years away and frankly needed today, that seems like a bridge too far.

Mr. PITTS. All right. My time is expired. Let me make it clear as chairman of this subcommittee, I support ICD-10, moving forward to ICD-10 rather than another delay. We need to end the uncertainty, in my opinion, move forward to full implementation of ICD-10.

At this time I will recognize the ranking member, Mr. Green, 5 minutes for questioning.

Mr. GREEN. Thank you, Mr. Chairman. I would like to ask unanimous consent to submit for the record the article showing ICD-10 implementation cost in small physician practices are dramatically lower than expected.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. GREEN. Thank you, Mr. Chairman.

Dr. Terry, I know that you, coming from Texas, you probably feel like you are the Alamo.

Dr. TERRY. I have my Kevlar suit on.

Mr. GREEN. And I appreciate urologists. I work a lot like all of our committee members on the committee work a lot with our specialties because delivery of health care. The biggest issue I hear from them is not ICD and obviously it is SGR, and I have served with some really great members from Mobile. You have a beautiful city. Sonny Callahan was a good friend and Joe Bonner, and you have a history of sending good hardworking Members to Congress from Mobile.

Mr. Averill, you mentioned that ICD-10 testing is still ongoing. For those who are preparing the transition, do you expect ICD-10 implementation to run smoothly come October 1st?

Mr. AVERILL. Yes, I do. I think there has been extensive opportunity both on the commercial payer side and the CMS side to do end-to-end testing. CMS has a whole series of end-to-end opportunities for those who are prepared and are willing to participate.

I want to emphasize that for CMS, this is a relatively routine update to their claims processing system. This is their core competency. I submitted in my testimony that they have had some difficulties with consumer-facing Web sites but this is their core competency, namely updating the claims processing system.

Mr. GREEN. Well, I hope they are doing some run-throughs before October 1st so we don't have what we had when some of us wanted the Affordable Care Act to roll out much more easily.

What about those folks who haven't begun to prepare for transition? Can they still be ready by October 1st? Here we are in February.

Mr. AVERILL. I have been very impressed with how the market has responded with educational material out there, much of it for free. The market has really responded. Most vendors have converted their systems to ICD-10 and are by and large making that

available to their clients for free, and so the whole infrastructure is there on a much more sophisticated basis than it was even 1 or 2 years ago, so I remain confident that those who are lagging behind at this particular point in time if they are willing to expend some effort to get prepared, those resources are readily available.

Mr. GREEN. I have another question for you, and I only have a couple minutes left. You testified the effect of the current ICD-9 coding system with diagnostic related groups, or DRGs. DRGs are used to classify hospital cases into groups for the purpose of reimbursement. Does the fact that ICD-10 is almost 40 years old have an effect on DRGs?

Mr. AVERILL. Absolutely. As I said, it is not uncommon to have reasonable requests from the industry suggesting an MS DRG change. Very often if you look at the Federal Register, you will see CMS saying we had this suggestion, unfortunately we weren't able to evaluate it because there is no ICD-9 codes to evaluate that particular aspect.

Mr. GREEN. Who is most affected if the DRGs aren't modified property?

Mr. AVERILL. Well, I think the whole industry is—hospitals' financial viability, reputations of individual institutions because they are often used for evaluating—or a component of evaluating quality of care. I think it is pervasive throughout the industry. It is absolutely critical that we keep MS DRGs up-to-date and reflective of today's medicine.

Mr. GREEN. Ms. Bowman, what types of training and resources go into preparing for ICD implementation and what is the cost of delaying?

Ms. BOWMAN. The cost of the training that goes into implementation has to do primarily with training coders on using the code sets and other users in understanding what the changes in the data are going to look like after the code sets are implemented, and also changes to systems and those personnel in understanding what changes need to be made.

Also, a big factor is clinical documentation improvement, and so I would say the biggest factors are probably training coders and then training physicians on improving their clinical documentation, but we found that there is a growing marketplace for tools in helping with the clinical documentation improvement because ICD-10 actually lends itself better because of its logic and specificity for those types of tools so that is turning out to be not as burdensome as some had feared initially.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the Chair Emeritus of the full committee, Mr. Barton of Texas.

Mr. BARTON. I thank you, Mr. Chairman, and I appreciate you holding this hearing. I think it is good to have transparency.

I would point out, in our memo for this hearing, we have a coding error. The memo talks about that the International Statistical Institute began in 1891 to begin the process of creating an internationally recognized classification of diseases. That is pretty cool. A hundred and 16 years ago they started doing that, so we have our own coding problems on the committee staff.

But in any event, I think it is pretty obvious when the committee chair or the subcommittee chairman says that he supports this, and he is the chairman, and the ranking member seems to support it, that we are supportive. I haven't had a chance to talk to either of those gentlemen, and I am not opposed to going to ICD-10 but I do have some concerns, and they are more at the CMS level than the panel, but I don't see why it has to be an either/or. I don't see why CMS has to arbitrarily say this is going to be the way it is come hell or high water.

I don't know enough about the coding systems and the computer programs and all that. I would have thought that ICD-10 would build on ICD-9 and that they would be compatible so that you didn't have to choose. Dr. Terry, is that not true? I mean, are they so different that you couldn't use either one or the other?

Dr. TERRY. Well, the codes are very different. Yes, sir, they don't—I mean, it is just not an exponential increase in the codes but it is a mindset. It is different rules. It is just totally different.

Mr. BARTON. I don't have my Congressional phone with me. This is my campaign phone. It is an iPhone. My Congressional phone is still a BlackBerry, and nobody made me switch to this phone for campaign purposes. As all the members up here know, we have to separate our campaign communications from our Congressional, and the iPhone seemed to be better, and so that is what the campaign bought. But there is no FEC law that says I have to. If I still wanted to use a BlackBerry on the campaign, I could.

I will ask the doctor on the end here, I can't see your nameplate, sir, but I listened to you. Why couldn't CMS provide incentives to switch to—our Medicare, for that matter—to switch to ICD-10 by payments, but if a family practitioner or a doctor in a small practice didn't have the money or didn't want to, you know, let them use ICD-9 and not—they might not be reimbursed as much but they could still get something, and if you were in a more specialized practice that needed more complicated codes, do it that way so it is not an either/or.

Dr. HUGHES. I am not a health economist or an administrator. The idea of incentives is inherently appealing to me, but I don't know, it seems to me like that would cause lots of duplication of effort on the part of CMS, which might be prohibitively expensive, but that is just a question I am raising. I can't answer that question definitely. Some of the other folks on the panel may be able to.

Mr. BARTON. Well, my point is, you know, you can make things happen by punitive measures or you can make things happen by incentives, and in this case, it looks like we are trying to be punitive by saying no matter what, you have to do it, and I don't know for the life of me if I am in whatever business I am in, if I want to conduct my business on way, I know I may be penalized by not being reimbursed as much or not getting as timely a payment or something, but you know, I don't know why we have to force people into a system that for whatever purpose they just don't feel like they are ready to go to.

Dr. Burke, do you have any comments on that?

Dr. BURKE. I would say just in general, I mean, ICD-10 is a lot better program than ICD-9. I mean, it makes it easier to find the

diagnosis, so actually would probably spend less time in the room with the patient with an ICD-9 code.

Mr. BARTON. Well, from an insurance perspective and from a data information perspective, I agree with you, it is more specific and all that, but from a practitioner perspective, I am not sure that I am following that. I would like to see CMS work with the user community at the provider level and come up with a way to incentive it without telling them they had to do it.

With that, Mr. Chairman, my time is expired and I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the lady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Well, thank you very much, Mr. Chairman, and thank you to our experts for your testimony here today.

So what I understand is the International Classification of Diseases coding system number 9 has been in place in the United States since 1979. In 1990, a new classification system, number 10, was adopted. In 1996, the Congress gave general direction for the United States to move towards that coding system. While the United States has delayed it for many, many years, 38 other countries have transitioned to that modern ICD-10 coding system.

The United States is typically a world leader but it appears that unfortunately that is not the case when it comes to the modern coding system, and the problem is that based on all the evidence I have seen, that has been very costly for our country and for practitioners. A number of studies have concluded—HHS did an analysis in 2014, the RAND Corporation did an analysis, and we are working about billions of dollars in the American healthcare system, and many of you have testified today about the cost. So I would like to join my colleagues in urging no more delays in the transition to ICD-10, and especially I urge the leadership not to include delays in must-pass bills, especially something as important as how we pay doctors that see Medicare patients. Let us stick with the October 1st deadline.

Another reason is since 1979, think about the changes in health care that has been mentioned today. New medical devices, new treatments have been developed, and our coding system has to reflect modern medicine. The consensus, as I understand it, is more specific codes will help us make great strides in healthcare quality, and all of you have mentioned how important it is for America to transition from paying for quantity of care to quality of care, and it appears to me that more specific data will help payers implement incentives for better patient outcomes. Better specificity will help the providers who we are increasingly holding accountable for patient safety, readmission rates, patient outcomes.

So I would like to focus on a couple of things. I also heard Dr. Hughes testify that the change in the codes will be important to improvements in research, the importance of identifying factors and circumstances that account for complications of care in order to reduce their occurrence. Can you talk a bit more about how ICD-10 will help with research initiatives?

Dr. HUGHES. The kind of research that I do and many other people do in attempts to improve quality all depends on data. That is what is needed. It has to be accurately recorded. It has to be precise enough that actually makes some difference, that it is specific

enough, and with specific-enough data, you can track patterns, you can track the introduction of new procedures, and all that makes the quality of the research much better and makes the results more accurate.

Ms. CASTOR. How does it make the quality much better in the long run?

Dr. HUGHES. Well, because you are able to identify specific actions, you are able to identify specific new procedures. When you have a new type of minimally invasive procedure, for example, you don't have to categorize that as another open procedure or ICD-9 to categorize those new procedures as other types of cardiac surgery.

Ms. CASTOR. What type of diseases are you talking about?

Dr. HUGHES. Well, here I am talking about cardiac surgery on the procedure side, but the new procedures are being expanded into gastrointestinal surgery, to lung surgery, you name it. There are illnesses on the diagnosis side. There are illnesses that arise or illnesses that differentiate. We have new categories of malignancies.

Now, you can always add an ICD-9 code but at this point we are pretty full. ICD-9 really has not that many more codes that you can cram new information into so you have to add a code that is out of—you know, put it in a different chapter or you have to lump it in with a whole lot of other things. So the specificity can make a whole lot of difference in terms of tracking illness and tracking new interventions.

Ms. CASTOR. Thank you very much.

Mr. PITTS. The Chair thanks the gentlelady and now recognize the vice chair of the committee, the gentleman from Kentucky, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman, and I want to start with Dr. Burke.

I have talked to different people about ICD-10 conversion, and we went to estimate to cost to implement this, as much as \$84,000 and as low as a few thousand dollars. Could you help the committee understand what actual costs are faced by the doctors' offices as we move forward?

Dr. BURKE. That is a good question. I don't know, because for us, it didn't cost anything. You know, it was just another day in the office, you know. Day one we were using ICD-9, the next day we were using ICD-10.

Mr. GUTHRIE. No cost to transfer over?

Dr. BURKE. No, no. Our software vendor was the primary factor in getting that done but, you know, there is no cost to us.

Mr. GUTHRIE. Well, thanks.

And Dr. Terry, I will get to you in a second on that. I have got a question.

There was a new GAO report out Friday, and it finds that while some concerns persist—and a unanimous consent to enter this into the record.

Mr. PITTS. Without objection, so ordered.¹

¹The information has been retained in committee files and also is available at <http://docs.house.gov/meetings/IF/IF14/20150211/102940/HHRG-114-IF14-20150211-SD006.pdf>.

Mr. GUTHRIE. It said that CMS has done notable work to address concerns, providing educational tools, opportunities for testing, and Ms. Bocchino, is it your belief that resources and testing are available to those who want to be ready by October?

Ms. BOCCHINO. Absolutely. And if I can make one other comment, they are providing all kinds of outreach and educational testing as well as end-to-end testing with claims and getting providers accustomed to the new.

I also want to comment that running dual systems is just not feasible, even on the private-sector side. It is very costly, and what the plans are going to be doing on October 1st is they are going to be switching to new clinical policies and new algorithms based on the new codes, and having two tracks will just create more confusion for providers as well as for payers. It is important to send a very strong message that we are going to implement on October 1st.

Mr. GUTHRIE. I want to talk to all the panelists, but I want Dr. Terry to go first, give you an opportunity. I married an Alabamian, so I appreciate your accent very well. My dear wife is from the Shoals.

My question, well, there has been delays going on—well, first of all, I appreciate your concern because I know as things change in administration and health care and the Affordable Care Act, it seems to smaller individual or small personal practice, this is a bigger practice and a hospital has more administrative ability to cover their overhead, and we understand that. And also you have—Mr. Barton talked about it—I just switched to an iPhone. The reason I didn't for so long is because of the cost, time costs more than anything, but it was my decision because I was paying for it and my time just sit down and really learn how. I know how to use the BlackBerry. And so the difference was, it was really my decision because I was—although people in Medicare pay through payroll taxes, they pay through their taxes, they pay for their health care, but it goes through a third party. And so as we try to get information on what is being paid for, controlling costs of what is being paid for, that information is important to the people paying for it, which is really the taxpayer overall, so I understand your issues moving forward. And so the question is, with the GAO, the resources, I will start with Dr. Terry and all the others, we have had two delays administratively, one Congressionally. I mean, in the meantime, you see it coming, and what have you all been doing, people with practices that are smaller than hospitals or megapractices been doing to move forward knowing it is coming?

Dr. TERRY. Well, it has been entered into the record. We sent an attachment, the study that was done by an independent group a year ago that shows the costs that I quoted in my testimony, and that is true for my practice. We paid enormous costs to our computer people just to put the thing in. Some people have contracts and they don't have to pay the cost. We paid a lot of money, and if you send people off to—if you sent me off to a course to learn how to do it, that is more than \$5,000 right there.

Mr. GUTHRIE. Plus your time.

Dr. TERRY. So the cost—but we are not here to debate that, and we are not here to debate—I think to continue to delay it is not

the right answer. Now, you are surprised I said that. You can delay, delay, delay but whenever that time certain date is, we are still not going to be ready, and it is because it is a flawed implementation. It is a big buying approach all in one day. The industry says it takes a year to get ready for this. How can you spend the time and effort and resources to prepare for something that is a year away when you don't know what it is going to do and then you don't even know when they turn the switch if it is going to work?

We need a transition. The problem here is the implementation. Now, I can argue the product, why are using 80,000 codes, the rest of the world 20. How can we compare data with the rest of the world when we have 80,000 codes and they have 20? How do those compare? But the problem here is the implementation, and it needs to be some kind of transition we have to figure out.

Now, the dual system, I have heard CMS say they can't do it. I heard the Blue Cross Blue Shield man yesterday at the ICD coalition meeting say they are already doing it. So it can be done, and I don't know if that is the best thing to do, but we have to—physicians have to have a guarantee that we are going to get paid if we don't code right.

Now, remember, why does coding have anything to do with how we get paid? We provide a service, and you are not going to pay me because I coded wrong? Everybody can't run a 4-minute mile. Some doctors aren't going to be able to do it, and do they deserve the death sentence and be put out of business?

Mr. GUTHRIE. I understand your concern with that, I do. I appreciate it. Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Oregon, Mr. Schrader, 5 minutes for questions.

Mr. SCHRADER. Thank you, Mr. Chairman. I appreciate the opportunity. I appreciate the opportunity for the hearing.

I guess, Dr. Burke, first question is, how many additional codes did you feel you had to deal with in your practice compared to ICD-9?

Dr. BURKE. Not many more. I would say maybe 10 or 20 percent more.

Mr. SCHRADER. OK. Then for Ms. Bowman, I guess, are there tables out there that would help private practitioners figure out what additional costs they are going to have to use? In other words, if you are a urologist, is there a set of codes you can handily go to or is this all done alphabetically and you have to figure out what code out of the list of 10,000 is going to fit your particular situation?

Ms. BOWMAN. Well, the classification itself is organized by body system chapter, so the different specialties are typically organized together, and a lot of the medical specialty societies have developed cheat-sheet resources for their members on the codes typically used in that community.

Mr. SCHRADER. So Dr. Terry, would you agree on this one point, anyway, that there is an ability to figure out what codes are relevant to your particular style of practice?

Dr. TERRY. Well, sure. One of the comments is that I am only going to have 50 or 60 codes as a urologist, but there are unin-

tended consequences here, and Blue Cross Blue Shield of Alabama makes me code 10 diagnoses for every patient encounter, so I have a patient with a kidney stone, I can code that easily, but I have to code their diabetes, their coronary artery disease, their high blood pressure. Diabetes has 250 codes, and if I don't do that, then Blue Cross—we are talking about Medicare and CMS, but guess what? We get paid by Blue Cross and United Health Care and Aetna, and it is going to kill me. I can't sit there and go through all those codes.

Mr. SCHRADER. Ms. Bowman again, what do you see the role of ICD-10 versus ICD-9 in combating fraud and, you know, abuse of coding, if you will, that occasionally goes on by the very few practices?

Ms. BOWMAN. For a lot of the same reasons that Dr. Hughes mentioned as the benefits of the specificity, it actually will help prevent and detect fraud, because right now there are so many services or diagnoses that are lumped into the same code, sometimes those that are covered and noncovered services are lumped into the same code. So as I often describe in some of my presentations, you can kind of hide behind the gray areas of ICD-9 whereas ICD-10, the specificity is such that it is black and white. The documentation should support what the specificity of that code is, and it should be much clearer, both to the provider in trying to assign the right code and the auditor or payer trying to determine that the correct code has been assigned.

Mr. SCHRADER. OK. I guess, Ms. Bocchino, when they talk about cost, there seems to be disagreement. It is a relative level of costs that a practice or a hospital or provider would incur. There are different styles of practice, and medicine is changing. Even in my little veterinary medical world, our practice has changed dramatically in the last 35 years. Could you comment a little bit about the contrasting views we have heard today about the cost to the practice?

Ms. BOCCHINO. I think a lot of it has to do with the contracts they have with vendors as actually Dr. Terry did mention, and if they are doing a lot of this internally and not using vendors externally, a lot of it is, do they have their own systems that they would have to go in and pay the cost of upgrading their own systems versus working with a particular vendor who is going to be responsible for all that upgrade, and it is just embedded in the contract. Also, some of the studies are more current now and so we have gotten more data on cost as more and more practices, particularly small practices, have begun the transition to ICD-10, and to comment on what Dr. Terry said before, right now some of the plans are using dual systems because some of the providers have converted over to ICD-10, but that has to stop because they are losing money on the additional costs that they have to put in to have both systems. This can't go on forever.

Mr. SCHRADER. I guess, Dr. Terry, last question for me anyway would be, you know, the system is changing. It used to be—I was a veterinarian. I just provided a service and I knew I was doing a good job. My patients got better. My clients were satisfied at the end of the day. But medicine in general seems to be moving to a more value-based outcome system. It is very different than my fee-

for-service system. And frankly, we are asking the Government and the taxpayer to fund a lot of this stuff.

So what is your thinking on, you know, the evolution of medicine here? I mean, you and I are a little older than some of the young bucks coming up these days, and they are going to the computer to figure out what the diagnosis is and stuff as much as relying on their own instincts. How does the movement to value-based medicine affect our view of this coding system?

Dr. TERRY. Well, you are right, I am a dinosaur but I know how to turn on a computer.

Mr. SCHRADER. I do too.

Dr. TERRY. You just opened up a whole other can of worms, what I think about value-based payment. We don't even know how to define value, OK, so how can you pay for value when we can't even define it? You know how as a patient if my treatment is valuable but how is the Government going to define it? I am not going to go there, but that is the problem with it.

You know, they talk about these statistics but, you know, in medicine, we have something called the scientific method, and it is not statistics. These codes are for statistics, not for research. Now, you can do statistical research but you can't do medical research. It is not the scientific method. So I have concerns about some of the amendments and argue of the benefits of all of this.

Mr. SCHRADER. Thank you, and I yield back.

Mr. PITTS. The Chair thanks the gentleman and recognizes Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman, and again, I thank you for holding the hearing. A busy morning, several things going on, so I apologize for my absence through part of this. If there is a question I ask that has already been asked, I ask that you be indulgent and not point that out to me.

On the issue of value-based services and pay-for-performance, I mean, Dr. Terry, I just have to tell you, there was never a morning when I drove to work in my OB/Gyn practice in Louisville, Texas, where I thought to myself, boy, I really hope I can be average today. You go to do your best work every single day. That is why you show up. That is why you are there for your patients, and I am a little troubled as is Dr. Terry about the fact that we are talking about a system that basically revolves around reimbursement and not so much the deliverable to the patient which, after all, at the end of the day is where we should be concerned.

But the concept has been discussed about having a dual system. Dr. Terry, do I understand you correctly that you would see perhaps value in running both systems simultaneously for a while after October 1st?

Dr. TERRY. I am not an expert on that but the value is that it is a way to transition. It is a way to let doctors get that year of experience and learn how to do the coding so that they don't—when we turn the switch and they are not ready to do it that their income doesn't go to zero, so that is the value. Now, whether that is the way to do it or not, there may be other ways to do it.

Mr. BURGESS. Well, it is interesting that you bring that up, because if you go to the CMS Web site, and I don't spend a lot of time but when I do go, I do go to the Frequently Asked Questions sec-

tion and there is an item that says dual coding, does my practice need to use both code sets during the transition, and the answer is, practice management systems must be able to accommodate both ICD-9 and ICD-10 codes until all claims and other transactions for services prior to the compliance date have been processed and completed. Well, that is CMS jargon for “we are not giving you a date.” So, you know, under their own information on the Web site, maybe the problem is solved.

You know, you go to other areas on their Web site and you try to click on the video for how you do this in your own office, and you are taken to an outside Web site that you need a username and a password, so you develop a username and a password, you click on it again, and the site is broken. So I mean, there are some real obstacles that you as a practicing physician when you try to do your due diligence and make sure everything is going to go smoothly, there are some obstacles put in your way.

Ms. Matus, your provocative statement to us, and I would love to go—but the chairman has already done it so I won’t put the committee through it again, but pull the plug or pull the trigger. I mean, I would just love to go down the line and say trigger or plug, but I think I know what your answers are.

But even at—and I do want to say, your CEO came to talk to one of our roundtables and provided one of the most refreshing views of ways to go forward with things that I have ever heard, so a lot of respect and affection for your CEO at Athena Health, but even on your own Web site, the Frequently Asked Questions on the Athena Health Web site, number 7, “How can the transition to ICD-10 impact my cash flow.” The answer here is instructive. It says “CMS estimates that in the early stages of implementation, denial rates will rise by 100 to 200 percent and the days in accounts receivable will grow by 20 to 40 percent.” Those are pretty significant figures, and I will just tell you from having run a small practice that you extend my days in AR by 20 to 40 percent and I am probably having to go downtown and ask my friendly banker for a short-term loan at a high percentage interest rate in order to keep my practice afloat. Is that a fair concern of the practicing physician out there?

Ms. MATUS. I think I am going to add on what Ms. Bocchino said. It depends on what software provider you use. As I mentioned, we do guarantee ICD-10 performance, and part of the reason that we can do that is, we have one completely Internet-based system. So if we, for example, have a claim rejected for one provider, we can go out overnight and make sure that any other claims that are in queue that look similar to that are changed so that they will go through appropriately the next day. So I think, you know, again, it depends on what system you are using and how you are formatted, but there are ways to make this easy to do, and when you think about ultimately—when you heard John, we are so focused on building the healthcare Internet, and to be able to do something like that, you need one language. If you think about how we live our lives today, we have one system for financial information, we have one—you know, all our information, all our music is on our phones yet our health care—I have lived in six States, 10 years in the great State of Texas, my healthcare information is scattered to

the winds. So this is really important I think long term for foundationally building a healthcare system that is integrated.

Mr. BURGESS. Right, but for those practices that did not have the foresight and intuition to align themselves with your organization—

Ms. MATUS. There is still time.

Mr. BURGESS [continuing]. They may be in difficulty.

Mr. Chairman, I do want to submit for the record a series of questions by Daniel Chambers, who is the Executive Director of Key Whitman Eye Center in Pete Sessions' district back in Texas, and I just want to point out one of the things that he says there is that physician offices may need to be prepared to go out and cover this delay in accounts receivable for an extended period of time, and under existing tax law, we are in our practices are not allowed to carry over money in our practices or it is taxed and then we are going to pay taxes on it twice. So this is an untenable situation that a lot of practices find themselves in.

Mr. Chairman, I thank you for the indulgence. I do want to submit this for the record.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from California, Mr. Cárdenas, 5 minutes for questions.

Mr. CÁRDENAS. Thank you very much, Mr. Chairman.

I would like to thank all the witnesses for apprising us of the perspective that you bring and thank you for representing all the constituency interests that are so important to the health care of all of our constituents throughout the country. Thank you very much.

My first question is to Mr. Averill. I understand that there are concerns that increased number of codes may be a burden for physicians, and I am glad you testified on some of those reasons earlier regarding the switch to ICD-10 and how it would in fact be an excessive burden for some practitioners. You recommended specifically that no individual would need to know all the codes obviously, just like was mentioned smartphones. This thing seems to be smarter than me. There are things that thing does that I don't even know where to start.

I would imagine that with today's technology looking up codes by doing a word search, for example, would be very simple and wouldn't hinge much on how many codes are available, again not having to know everything but just being able to utilize it accurately and effectively is what I think every practical system is expected to do.

I have a question. Would it be—would I be right to assume that modern technology makes more comprehensive coding systems like ICD-10 manageable?

Mr. AVERILL. Yes, they do, and since the iPhone has gotten quite a bit of visibility today, there is an app for I-10. It is a free app, and you can look up an iden code. If you wanted to really splurge, there is one for \$1.99 that will give you a few bells and whistles on your iPhone to look up a code, and if you take that technology, in a few seconds you could look up almost any I-10 code.

Mr. CÁRDENAS. OK. So the technology of today makes it much less burdensome than the implementation of years past, correct?

Mr. AVERILL. Correct.

Mr. CÁRDENAS. Mr. Chairman, for the record, before I run out of time, I would ask to submit, the California Hospital Association asked me to submit a letter to the hearing record that states they are ready for the announced October 1st, 2015, ICD-10 compliance date and urges Congress to avoid any further delays, and I would like to submit that letter for the record, Mr. Chairman.

Mr. PITTS. Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. CÁRDENAS. Thank you so much.

Carmella Bocchino, did I say your name right? Thank you. I have heard the argument that given that the World Health Organization will be implementing ICD-11 in 2017, the United States should just wait to implement that coding system. I also understand that there is an argument that implementing ICD-10 makes it easier to eventually implement ICD-11 down the road. My question is, would skipping straight to ICD-11 be counterproductive, or what is your opinion on that?

Ms. BOCCHINO. Our opinion is no, it would be counterproductive in that—

Mr. CÁRDENAS. How so?

Ms. BOCCHINO. ICD-10 builds off of ICD-9, and there has been a lot of resources and training and effort gone into many, many people in the healthcare system, not just payers, to get us to ICD-10, and you end up penalizing them for all the resources that they put forward already if you are now going to make the jump and continue to use what I think is an antiquated system in ICD-9.

Mr. CÁRDENAS. One of the arguments again, Ms. Bocchino, one of the arguments in any change is come on, we are looking at this with a broad brush. It doesn't necessarily help the individual constituent or the individual patient in this case, but one of the things that I believe that this system makes sense and the fact that the whole world or at least most of the world seems to want to comply and is doing what they can to do so. I think the United States should follow suit.

Doesn't it, at the end of the day, come down to the individual knowing more about what diseases are going on and going around now that the world is getting smaller every day?

Ms. BOCCHINO. Absolutely.

Mr. CÁRDENAS. At the end of the day, doesn't it directly affect the individual patient?

Ms. BOCCHINO. It does. It affects the individual patient both in the sense of us knowing a lot more about complication rates, about a lot of the research that actually Dr. Hughes raised up, which is going to drive better patient care and engage patients to better take care of themselves.

Mr. CÁRDENAS. Isn't it today more than ever doctors communicate with each other telephonically, electronically? My understanding, I just had somebody—I helped somebody put somebody in touch with a doctor who lives in northern California, the patient was in my district, and lo and behold, within 24 hours that specialist was looking electronically at some information so that he

could give that second opinion where that patient was in the hospital, couldn't physically go see that doctor, but yet again, my point is that communication, that is happening more and more today, and that is a good thing, right?

Ms. BOCCHINO. It is, and it is happening a lot more in rural areas where we don't have a lot of specialization and you need exactly that kind of connectivity.

Mr. CÁRDENAS. Thank you very much, Mr. Chairman. I exceeded my time. Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman, and I appreciate that very much. I appreciate the witnesses being here today.

Dr. Terry, if you could help me out on this, I know we apparently got smartphones and all kinds of computer programs that will help you with the ICD-10, but they also come out in book form, do they not, the ICD-9 and the ICD-10? And my understanding is, the ICD-9 is about one volume about yea thick. Is that right? If you can answer for the record?

Dr. TERRY. Yes, about 2 or 3 inches.

Mr. GRIFFITH. And that the ICD-10 would be about four of those same size books. Is that about right?

Dr. TERRY. I have not seen it but it makes sense.

Mr. GRIFFITH. All right. And you indicated earlier that the rest of the world is using 20,000 codes but that we are about to use 80,000 codes, but then I heard testimony that the World Health Organization is coming out with an ICD-11. Is most of the world using the ICD-10 already or is that just aspirational?

Dr. TERRY. Yes, the rest of the world is using ICD-10, but it is like you are comparing apples and oranges. The rest of the world is using less than 20,000 codes and they don't use it for billing, they don't use it in the outpatient setting. But you are saying oh, we have to keep up with the rest of the world but we are doing it totally different.

Mr. GRIFFITH. OK. So if we do it the rest of the world did it, then you would be OK with it, or you could at least figure it out. Is that a fair statement?

Dr. TERRY. Yes, sir.

Mr. GRIFFITH. And you said something about how many codes there were for diabetes, and I failed to write that down. How many different codes are there for diabetes?

Dr. TERRY. Two hundred and fifty.

Mr. GRIFFITH. Two hundred and fifty codes. I guess my problem with the ICD-10 and this whole concept, and it comes down to part of what you are saying. It would seem to me to make sense that you could do a dual system. Now, ultimately, you want to get everybody on ICD-10. I get that. But if you submitted for a period of years ICD-9 and ICD-10 and if you got either one of them right, you got paid, then that would probably alleviate your fear and concern. Is that correct?

Dr. TERRY. My fear is just being able to take care of the patient and not being put of business because I code wrong. That is my fear, and how you can fix that? Like I said, there are several ways to do it.

Mr. GRIFFITH. And do you know what the projections are on the numbers of the shortage of doctors that we are anticipating having in this country?

Dr. TERRY. I don't know numbers but it is definite. I mean, there are fewer people wanting to go into the practice of medicine because of the financial aspects, and it is just—

Mr. GRIFFITH. And lots of paperwork and dealing with lots of computers instead of seeing patients. Is that right?

Dr. TERRY. You are talking about computers and statistics, but one thing hasn't changed, and that is the care of the patient, the sitting down and listening and examining and talking. Computers can't do that. And I don't have time to do that anymore. I am sitting in my office with my back to the patient typing on my computer trying to take care of my patient, and if you have a 15-minute office visit, that is getting whittled down by 50 percent now, and it is not all ICD-10. It is Meaningful Use, electronic medical records. It is trying to learn how to deal with this, but ICD-10 is going to pile on it.

Mr. GRIFFITH. And as a result of that, it wouldn't surprise you that either last year or the year before that, I sat down with a doctor in one of my rural communities that I represent and his number one complaint was ICD-10, and he said look, I am getting old, I am not a dinosaur but I am getting old, or older, and I love serving this community but I don't know if I am going to continue to practice.

So you would anticipate that pushing with a drop-dead date, as Dr. Burgess pointed you earlier, the dual coding is only going to happen up to a certain date, not allowing for things to go forward after that. You think like him that there would be a lot of other doctors that may decide that it is just time to go ahead and retire and enjoy their house at the lake?

Dr. TERRY. There is no question. I already have a doctor in Mobile that has already quit because of the thread of ICD-10 plus he didn't want to have to take his boards a fifth time, and there are a lot of people—you know, I am 60, 61, you know, there are a lot of people between age 61 and 65, they are not going to do it. Now, how do you measure that? I am just telling you it is going to happen.

Mr. GRIFFITH. So what we are going to see is that my allergist, who served my family for five generations and who didn't stop practicing until 1992, and even though his body was getting weaker all the time, his eyes flashed and he always knew what was going on, you are indicating to me that we are not going to have those doctors continue into practice as long and that that is going to create a problem in our rural communities, notwithstanding the fact that some of the younger doctors like Dr. Burke will figure it out, but it is going to create a shortage of doctors, particularly in the rural areas. Am I correct that that is part of what you are saying here today?

Dr. TERRY. Yes, sir, but it doesn't have to be that way if we can change the ways being implemented. It doesn't have to be that way.

Mr. GRIFFITH. Well, I appreciate you being here very much. I appreciate everybody else, and I understand for big practices and big

cities, all of this is easy, but it is not so in the rural areas where we are already having healthcare shortages.

Thank you. I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes Mr. Long from Missouri, 5 minutes for questions.

Mr. LONG. Thank you, Mr. Chairman, and thank you all for being here today.

When I was elected in 2010, and we came up for orientation that next week, there was 96 new Congressmen out of 435, and we were all excited, and they gave us our little briefcase with things in it, documents, everything we need, and they gave me a BlackBerry, and I said, "What is that?" They said, "Everyone gets a BlackBerry." I said, "I don't get a BlackBerry." They said, "Why not?" I said, "I have never had one, I don't know how to use one." I get an iPhone. "No, no, no, we don't get iPhones, you get the Government issue, you get a BlackBerry." I said, "I don't want it, I can't use a BlackBerry, I don't want to relearn a BlackBerry." So I was the first Congressman that changed the policy here, so I hold the record. I was a 55-year-old freshman at that time. I was a 55-year-old trendsetter. So I got my Government-issued iPhone, and now they give them to everybody. I know it is a little off the subject, but that is what all the discussion was on iPhones or BlackBerrys here this morning.

And Dr. Terry, you do the best impersonation I have ever seen of my doctor in Springfield, Missouri. I should say my former doctor, because when Obamacare first passed, I went to see him, and you remind me of him because I told him, I said if you don't settle down, I am going to have to check your blood pressure. He turned around to the computer and he was working just like you imitated a minute ago, and he said I have got to do all this paperwork now. He said I have got 10 hours a week just on new things. He said it used to be I would send you out of here and now you have to sit there and answer these questions for me, and he quit about 6 months after that, and he was in the same age bracket as you and I, and he had several good years left in him. So I know that this is very disconcerting for a lot of doctors.

And for my friend from my State of Missouri, and you are from where in Missouri?

Dr. BURKE. Fredericktown.

Mr. LONG. Fredericktown. My mom's people originally came from Fredericktown, so we have got a little in common there.

You said—I don't guess you said it, but there are supposed to be significant public health benefits to the greater coding and reporting under ICD-10. Will you kind of discuss some of those benefits?

Dr. BURKE. I mean, you know, for instance, if, you know, someone comes in with COPD, or emphysema, you would put the code in, and it can talk about an acute exacerbation or chronic COPD, unspecified. So it gives us a clearer picture of what is going on with the patient.

Mr. LONG. OK. And I have heard of both of those, but the ICD-10 diagnosis codes have been readily mocked for their more obscure codes. For example, there is a code—I don't know if you run into this—but in our neck of the woods down in Missouri, you might

need this one: bitten by a pig, initial encounter. And walked into lamppost, subsequent encounter.

Mr. GRIFFITH. What about a subsequent encounter with the pig?

Mr. LONG. Maybe that is why he ran into the lamppost. A pig bit him, and he ran into the lamppost. Isn't this overwhelming for small solo practices in rural America like your represent, not that you have a sole practice, but I mean, you are out there in a town of 4,000 people.

Dr. BURKE. Yes, true. I don't think it's overwhelming. I think it is easier to find a diagnosis because you have a lot more choices for the diagnosis.

Mr. LONG. I would say you do if you have got "bitten by a pig."

Dr. BURKE. So, you know, I think it is—I just don't think it is overwhelming, not at all, not in the slightest bit. You know, for the scope of my practice, which is internal medicine, and actually our software is the one that helps us out because, for instance, if someone comes in with a complaint and there is an ICD-9 code in the chart, we can click on the ICD-9 code and then a bunch of different ICD-10 codes can show up, and we can go through the list and pick one which is more specific.

Mr. LONG. OK. You said in your opening remarks that it was—I am paraphrasing but kind of like a light switch. You switch one day from 9 to 10 seamless, no problem whatsoever. Dr. Terry in his answer to a question earlier I believe said that it would take \$5,000 in training to get somebody up to speed. Did you have to undergo any special training or spend any money or go off somewhere to learn this, or—

Dr. BURKE. No, I didn't, and neither did the nurse practitioners, so no one in our office did.

Mr. LONG. OK. And Ms. Bocchino, healthcare communities have had years to plan for ICD-10, including several delays. Have the insurers used this time to prepare?

Ms. BOCCHINO. Absolutely, and they have worked with the providers in their network to do end-to-end testing in providers of all size, so they have done a lot of outreach, even to the smaller providers. I will be honest that it is difficult sometimes to get the smaller providers engaged, but in part that is because many providers believe that we are going to keep moving the date, and until we are firm on a particular date that they know this is coming, I don't think we are going to get some of them engaged. I think it is very important to send a strong message.

Mr. LONG. OK. Thank you. I downloaded a couple of apps here on my iPhone on ICD-10 after we were advised earlier, but you said a dollar. Now, the first one that came up was \$4.99 but I did find some free ones, so I have got two apps. Now I can go study and see what is in there besides first encounter bitten by a pig, and I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman. I feel like old times up here today. This is nice. And I apologize. I was at one of the other subcommittees earlier, so this is why I missed your testimony.

But I wanted to ask Ms. Bowman, or Mrs. Bowman, I guess, you mentioned in your testimony that the demand for high-quality data is increasing due to healthcare initiatives that aim to improve quality and patient safety while decreasing cost. Can you explain how ICD-10 will interact with the electronic health records Meaningful Use incentive program, and what about other delivery system reform efforts?

Ms. BOWMAN. Sure. The ICD-10 codes in addition to being used directly for reimbursement like we have heard a lot about today is also used for a lot of administrative data reporting purposes where aggregation of data is important. So it helps to provide data for all these other programs like value-based purchasing, accountable care organizations to show the severity levels of different conditions so that you can link that to outcomes to best practices, to different treatment options and see really what works, what doesn't work, what is the most cost-effective form of treatment. If you have better information about what is really going on with the patient and the level of severity of a particular illness, not just a generic description for that illness, you can fine-tune that information a lot better and really drill down to what works and what doesn't work.

Mr. PALLONE. OK. Now, you also mentioned that the updated ICD-10 codes would help with reimbursement. Would you want to explain how it would ensure more accurate and fair reimbursement or more accurate codes would reduce providers' or payers' administrative burden, for example, in clarifying diagnosis and procedures?

Ms. BOWMAN. Sure. Because of the increased specificity, you can drill down to different forms for the same reason. They kind of give you better information on the different costs related to particular diagnoses and procedures. A great procedure example that I think Rich might have used in his testimony but I heard it before is, suture of artery. So we have a single code that is a procedure example, and it doesn't matter whether it is the aorta or an artery in your little finger. It is the same code in ICD-9, and obviously there is enormous differences in complications and the cost of repairing the aorta versus other types of arteries and yet we are lumping it all into the same code. So by having better specificity on the procedure side, a lot of it has to do with approaches, anatomic sites on both the diagnosis and the procedure side. We can really be able to fine-tune information about the cost of treatment, which then links to the appropriate reimbursement for that treatment.

Mr. PALLONE. And you mentioned about the cost and danger of continuing to use the ICD-9 codes. Who are those costs affecting?

Ms. BOWMAN. These costs are affecting everyone, our entire healthcare system, providers, payers, the patients because right now because we don't have that specific information and ICD-9 is just deteriorating and failing more year after year that we use it. We are getting less and less information for each clinical encounter, and basically reimbursement, analyzing quality of care based on that data are just wild guesses at this point because there are so many disparate conditions or procedures that are lumped into a single code, and in some cases some of the testifiers had talked about differences in ICD-10. Some of those differences have to do with just changes in clinical knowledge since ICD-9 was developed. So some conditions are actually categorized somewhat differently.

I believe there is even some medical conditions that are not categorized as cancer in ICD-9 but are categorized as cancer in ICD-10 because of changes in medical knowledge. So we are losing a lot of that information by continuing to use ICD-9.

Mr. PALLONE. OK. And then lastly, some providers argue that ICD-10 is unfair because it was developed by bureaucrats that have never practiced medicine, but you mentioned in your testimony that 95 percent of the requests for new codes in the past few years came from physician organizations. Can you just talk a little bit about how i10 was developed and who was involved?

Ms. BOWMAN. Sure, and that has been one of the biggest myths, I think, of ICD-10 is that it was developed in a back closet somewhere by bureaucrats. I have actually been involved in the development of ICD-10 since the 1990s now, and it is still being updated and maintained every year, and all of the content of the original ICD-10 that WHO uses, the clinical modification that the United States is trying to implement, all of it was contributed to greatly by the house of medicine who participated in the development, asked for that clinical data and continue today to come to public meetings that are hosted by the CMS and CDC to discuss proposals for new codes, and it is a completely public process. Anyone can submit a request for a new code. It is discussed in a public meeting. There are opportunities for public comments at the meeting or in writing afterwards, and CMS and CDC take all of those comments into consideration in making a final decision about adding new codes.

Mr. PALLONE. Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. BUCSHON. Thank you very much, Mr. Chairman.

I was a practicing cardiovascular surgeon for 15 years, so at the end of the day this is about money. This is going to cost physician practices initially, and I agree with Dr. Terry on the implementation. It is pretty clear that we are going to move forward on ICD-10, and we should, but I do have substantial concerns about the implementation and the short-term impact on physician practices because that will happen, and I am disappointed that some of the experts in non-healthcare fields that don't practice medicine are here today denying that will happen. That is very disappointing.

Ms. Bowman, have you ever practiced medicine? Have you ever had to bill a patient?

Ms. BOWMAN. No, I have not practiced medicine.

Mr. BUCSHON. Let me tell you what is going to happen, and I am going to—because you—and again, ICD-10 is going to happen. It needs an implementation plan. I agree with that. I don't think we have a disagreement there, but that said, here is what happens when you are a surgeon. You will do surgery, and it will be much more difficult for you or your people to find a code that matches what you write on your operative report. You know why? Because you are going to be in the operating room and you are going to dictate what you actually did. You are not going to look through an ICD code book and make sure it matches. And so when the insurance company gets the code and they get the operative report, they are not going to match, and it is going to come back to your office

and you are going to have to try to figure out, and then what do you do? Do you modify part of the official hospital record and say no, that is not—I had to change it to match a code? You could do that. But it will not make it more easy to get the correct code. From a practicing physician, my opinion, that is just false. That won't happen. So I am concerned about that.

Dr. Burke, is your practice independent or are you part of a larger healthcare system?

Dr. BURKE. There are two physicians and three nurse practitioners, and I am—

Mr. BUCSHON. So you are not part of a larger conglomerate that owns your practice?

Dr. BURKE. No, privately owned.

Mr. BUCSHON. OK. That is good because it is a rarity that that is happening today, and the reason is, is because the cost to run an individual medical practice is very difficult. I was in a 15-surgeon, 16 cardiology practice. We had to sell to the hospital. We couldn't afford to stay independent anymore.

But I was interested in your cost statement, that it didn't cost anything. What are your annual IT costs? What is your—how much do you pay a month for your IT service?

Dr. BURKE. I would have to talk to the office manager about that.

Mr. BUCSHON. My point is, you made a statement that said the cost is zero, and that is just false because you are making monthly or annual payments to your IT and this type of implementation is included in that cost.

We put an EMR in in 2005 in my practice. It cost us \$3 million up front, \$60,000 to \$80,000 a year just to maintain the current software. This is extremely expensive for medical practices. It may not be that, you know, oh, converting from ICD one day to the next cost you anything, but it is costly, and I think that that is something I want to clear up because I think that is just not accurate.

Ms. Matus, do you know what percentage of the healthcare costs are related to physician services?

Ms. MATUS. I don't know specifically.

Mr. BUCSHON. People estimate about 10 to 15 percent. Where is the rest of the cost to the American people for health care?

Ms. MATUS. I would imagine it is in administrative.

Mr. BUCSHON. Yes, about 25 percent is in administrative and then, you know, there is hospital expenses and others, right?

So, you know, the reality is, is that trying to continue to save Medicare or save our system by cutting reimbursement to providers is a failed strategy, and this is what this is about because what is going to happen is, is you are going to have physicians who are not going to be able to code this properly at all age groups except if they work for you, which it is great that you have a great system, but the individual physician out there is not going to be able to do this correctly, and their AR is going to go dramatically up and they are going to get denied, and it is not just for Medicare. It is going to be from every other private insurance company out there.

So I would encourage all of us who are involved in health care including on the administrative side to really look closely at our implementation plan and make sure that we can implement ICD—

10, which we need to, in a way that does not really cause dramatic problems with our healthcare system.

My practice, you know, we could afford to have a line of credit of \$1 million. With this kind of thing, we could front it for a few months. Many practices can't.

And lastly, Dr. Hughes, the example that you gave of a 74-year-old with a vascular injury, I did vascular surgery. Other than for your research and for statistics, how does that impact that patient's medical care? Because given your example, it has no impact on the outcome of that patient, not a single—nothing that—

Dr. HUGHES. I am sorry if I gave you the impression that that individual patient would be affected because you are absolutely right, it is not going to have any impact.

Mr. BUCSHON. It won't make any difference.

Dr. HUGHES. It won't make any difference to that individual patient. The point I was trying to make is that the accumulation of data is useful, and I disagree with Dr. Terry. I do believe that it is possible to look at data in a scientifically sound method and to derive useful information from it. We have got lots of information from the National Surgical Quality Improvement Program, for example, but you are absolutely right. It is not going to make any difference to—

Mr. BUCSHON. I just wanted to clear that up that in the short run, implementation of ICD-10—and thanks for your indulgence for a second, Mr. Chairman—will not have a direct impact on the individual patient care. It may in the long run based on your research, which I agree.

Thank you, Mr. Chairman. I yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognize the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. COLLINS. Thank you, Mr. Chairman. Sorry I was somewhat late. I was actually here on time, but I serve on Oversight. We were just ending a hearing on mental health, which I wanted to stay until it was over. So I missed most of the testimony although I did review the information, and just to set the stage, I am a supporter of ICD-10. I am a supporter of getting it implemented sooner than later. It has been on the agenda a long time. This isn't something that should be new to anyone. Most countries in the world are doing it. I certainly have a lot of physician friends, and I understand there is a cost of implementing anything new. You know, we can, I suppose, debate the benefits.

I am also a data guy. In my office I actually do have a sign that says "In God we trust. All others bring data." And I know that with data, whether it is analysis or other things we can do with it, while it may not be a positive for that patient today, at some point in time being able to deep-dive data, especially with healthcare costs going up in this country as they are, someone of my son's young age will be able to really use that data. He is very adept at that.

So I guess my question is—and feel free—I am sorry, I don't know who would be best at answering some of these, but I would see the data collection as a very major part of why we are doing it and maybe perhaps the other piece—I don't know if this came out—some identification of potential, I will use the word "fraud."

You know, the more data we have, the more specific someone has to be, and if someone could comment too, I would assume a lot of the coding will be done by the office staff. I mean, a dermatologist is going to be rocking and rolling. Her staff knows that I would think a lot of the coding would be coming from that. Is that a good assumption or bad, and could anyone speak to where this data would be helpful in the medical field going down the road?

Ms. BOWMAN. Yes, you are absolutely right. The data is very useful and helpful, and the fraud arena is one example, and the research that Dr. Hughes mentioned, yes, in most cases it is not necessarily going to help that patient today but the accumulation of data and knowledge about medical care will ultimately lead to better care for patients in the future.

There are some scenarios where it could help the individual patient today such as in the area of disease management. I know of some facilities now that are using the better diagnosis codes in their internal systems for disease management programs, particularly in the area of diabetes and asthma, because the clinical classification of asthma in ICD-10 is totally different than ICD-9 and is much more aligned to the way people are currently managing asthma, so I know of some facilities that are using the data that way.

With respect to the coding, obviously in hospitals almost all of the coding is done by professional coders who do the coding. In large practices, it usually is designated staff, and so there is a cost to the practice obviously, even in those situations of having the staff trained, and then in some smaller practices such as the Beyer Medical Group that is here today, it might be physicians who are actually doing their own coding but in a lot of scenarios it is usually a trained staff person.

Mr. COLLINS. So this has been implemented, am I correct, in other countries?

Ms. BOWMAN. Yes.

Mr. COLLINS. What have we learned—and we have only got a minute or so—the benefits of this has been evidenced by other countries having already implemented it?

Ms. BOWMAN. Well, Dr. Terry, I think it was, in his comments is absolutely correct. Other countries are not using it in the same way that we use it, and that is kind of a catch-22. That also makes it more complicated for us to implement it because of the fact that we do use it in our reimbursement system. So they didn't have some of the challenges and the costs and the issues that we are facing.

There was a comment earlier about not being comparable globally. However, we have a treaty with the World Health Organization for ICD. The modifications individual countries can make to ICD have to be beyond a certain character level in order to be able to maintain global comparability, and as I had mentioned in my testimony, almost half, actually 46 percent, of the additional codes in our modification are due to laterality, which is not in the international system, primarily because although they are actually oddly enough looking at that in the area of ICD-11. They are actually looking at what we did in our clinical modification as they work on ICD-11.

So there is comparability with the rest of the world because a lot of the detail, it has to do with ways we use the codes in our country that just aren't applicable to the rest of the world, the laterality and also there was significant request for—I know there was jokes about the subsequent encounter and initial encounter but those kinds of things, which are all in the seventh character, are where some of those additional codes come, and it is actually intended to improve our data from ICD-9, which right now if you have a follow-up encounter, it goes into a very generic aftercare code, which has been a big complaint for 30 years in the ICD-9 system that I can't tell that the reason I am seeing the patient was because they are being followed up for a fracture of the humerus. All I know is, it is orthopedic aftercare or a follow-up examination for who knows what.

So these encounter seventh characters were specifically created to solve that problem in ICD-10 so that it is an added digit to say you still use the original injury code but you know from this particular character that it is a follow-up visit and not the initial acute injury.

Mr. COLLINS. Thank you, Mr. Chairman. I yield back.

Mr. PITTS. Thank you. The Chair now recognizes the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman, and thank you to our panel for being here, and I too apologize for coming in late, so if any of the questions that I ask have already been answered, again, I just apologize. I am trying to get to the bottom of this issue.

First, I would just like to say I am a nurse myself. I practiced before coming to Congress as a nurse for over 21 years. My husband is a practicing general surgeon, and I will just have to say that my husband's opinion of moving towards ICD-10 is very much like Dr. Bucshon and Dr. Terry, although we know that this needs to be implemented at some point. I believe the frustration that exists within our medical community, especially our private practitioners, is that there is so much on top of them right now dealing with so much that now this is just one more issue that they are going to be forced to deal with. Many of our physicians and hospitals alike are still trying to meet stage II of Meaningful Use, and here we have yet another situation where we are going to have to deal with this.

So I want to get to the bottom of this. I want to see ICD-10 move forward but obviously we have to address the issues as they are in the realistic world rather than the theoretical world where this would be a wonderful thing as implemented. We just have to get there and apply it to the realistic world of health care and medicine as it is today.

So one of the big issues that we here continuously is, again, the cost, and the cost—you know, we know that our hospitals have invested millions in preparing for ICD-10, and I believe that that needs to be respected and we need to consider that for our physician practices, especially—and I know, Dr. Burke, you are practicing in a rural area—especially for our rural physicians and some of our smaller practices.

Dr. Averill, what can be utilized? Is there a cost incentive for physicians to embrace ICD-10 that you are aware of?

Mr. AVERILL. Well, first of all, let me say on the cost—there was just a recent study that was just released in which PAHCOM, which is the office managers for small physicians, surveyed their membership, and they asked the question, “What has been the expenditures getting ready for I-10 plus the expenditures remaining to be expended?” so the results of that survey essentially said for a small physician practice where that was defined as six or less direct caregivers, the average expenditures to date plus anticipated expenditures was roughly \$8,000.

Mrs. ELLMERS. OK.

Mr. AVERILL. And then there were two other studies that were recently published that actually came in with lower numbers. The market has really responded in terms of making the transition much easier and much more cost-effective. As I mentioned before, there is lots of free software out there. There is lots of free training material and so on. So I think in terms of what is available, the transition can be made. I think the biggest problem is the uncertainty, the uncertainty of should we invest the time, should we move forward when there is an uncertain date. You know, it is a tough competition for how you are going to spend your dollars. Do you want to spend it on ICD-10 preparation when it may not even occur? The most important thing is to say will it occur and when, and for once and for all, get that out there and let the industry move forward.

Mrs. ELLMERS. So again, just to clarify again from the cost standpoint, there is software available that physician offices can take part in. There are cost issues that can be addressed. And again, that is your position as far as addressing the cost issue for physicians and training?

Mr. AVERILL. Yes. The market has responded and those services are readily available at a very low cost, and it is a decision on the part of the individual physician office to take advantage of that.

Mrs. ELLMERS. Dr. Terry, would you concur with Mr. Averill on that?

Dr. TERRY. I thin, his comments represent the minority. I know plenty of physician practices who have paid a lot of money to—I mean, if you are stuck with an electronic medical records and you don't have a contract that says they are going to update it, you are stuck because you can't change it. They control our practices now that we got that electronic medical records. I have to do what the company tells me to do, and I can't bargain. I mean, it costs. I mean, this is—and I respect their study but their own people kind of did the study. I mean, are there conflict of interest in it? Are there—how is it done? Has it been repeated? But I respect what they did but I just think it is crazy to say there is zero cost or \$5,000 cost. It is more than that.

But, you know, cost is not what I am—it is not an issue to me. I don't care about that. The thing is the implementation and doctors not being able to stay in practice and taking care of their patients. I don't really care about the cost.

Ms. ELLMERS. No, and Dr. Terry, I agree. That has been one of the issues that I think we all have heard, and those of us who have been in the healthcare world, we want to give the best care we possibly can to our patients, and when we have been whittled down

to a few moments in the exam room with them and really understanding their issues, it really doesn't matter how much information we can gather. We are not gathering it because we are basically on a time constraint and there is much that will be missed.

So with that, again, I just want to say thank you, Mr. Chairman, and thank you to our panel. This is a very, very important issue, and I just hope that we can all come together to work on a solution moving forward so that we can continue to provide great health care to every American. So thank you.

Mr. PITTS. The Chair thanks the gentlelady. That concludes this round of questioning. We will go to one follow-up per side, and I will recognize myself for that purpose.

Dr. Hughes, when a patient's health care requires multiple providers, which coding system will allow the most comprehensive detail information sharing to ensure each has the best information to care for that patient, ICD-9 or ICD-10, and please elaborate.

Dr. HUGHES. ICD-10 provides more information. Let me reiterate that for the patient in front of you or in front of those several providers, it is not going to make a whole lot of difference. Hopefully the several physicians that are caring for this one patient are sharing information and they should not need a computerized data system in order to learn what their colleagues are doing or have done. So for the one patient, I don't think it makes a whole lot of difference but the difference comes when you are talking about patterns of use, when you are talking about how many doctors in this area use an assistant surgeon versus another area where you could be talking about some pretty considerable differences in cost because you get two surgeon bills instead of one, you know, the involvement, if there is more than one procedure, then yes, you want to have detail, but that is going to be billed anyway.

I think it is only when we look at the patterns and see how the technologies are evolving that that is where it is going to be really valuable.

Mr. PITTS. Does anyone else want to comment on that?

Dr. TERRY. I will just say that I don't treat my patient based on a code, and all of these electronic medical records, you think my office talks to the doctors in California through a computer? No. They don't talk to each other. That code only goes to CMS and the insurance companies to do whatever they want to do with it. One is to deny payment to us if we don't get it right. I don't take care of patients based on a code. That is just something else I have to do.

Mr. PITTS. Anyone else?

Mr. AVERILL. I will just make one observation in follow-up to that, that much of this additional specificity has been requested by the medical community. For example, the urologists that have been coming to the coordination maintenance committees over the last 3 years have asked for 200 new codes to be added to ICD-10, arguing that there is not enough—as much specificity as there is in I-10, the urologist community is asking for 200 additional diagnosis codes. And so we are kind of in a dilemma as an industry. There is continual pressure coming from the medical community for more and more precise information to be used for everything that we have talked about today, and at the same time, there is great reluctance to say that we are willing to collect it and submit it. So I just

find it very interesting that the urologists are demanding more and more information and that I-10 becomes further and further expanded.

Mr. PITTS. All right. Thank you. The Chair now recognizes the ranking member, Mr. Pallone, for 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I just wanted to ask Dr. Burke, you testified that ICD-10 is a better communications tool. What are some of the critical differences between ICD-9 and 10, and how have the more specific codes helped you in your practice with patient care?

Mr. BURKE. Well, as I said, it is a better communication tool, but I would say, for instance, ICD-9 code would be coronary artery disease, but an ICD-10 code could have which vessels involved or which graft is involved if the patient has had surgery. It was easier to communicate that with the patient in describing their clinical condition when you see them.

Mr. PALLONE. I mean, the concern is the large number of codes but, I mean, your experience in navigating all these codes with more than 100,000, I guess, now, it doesn't matter? I mean, in other words, it is not that much more of a burden?

Dr. BURKE. No, not at all.

Mr. PALLONE. OK. Let me just ask, Mr. Chairman, Mr. Averill because he was out here, you know, just testifying about the cost of another delay. Can you help us understand the effect each time implementation is delayed? What does the delay affect? What types of, you know, training and resources go into preparing for ICD-10 implementation? What is the cost of delay?

Mr. AVERILL. Well, I think it is twofold. One, vendors, CMS, payers have to essentially maintain dual systems. We have to be ready at any point once the final decision is made to go fully forward with ICD-10 or continue to support I-9 and all the various claims adjudication and all the evaluation of quality metrics and so on. We have to have parallel systems. That is a tremendous cost.

Further, the cost of the delay is the uncertainty of it all. We have talked a lot about having people be prepared and be ready, but in a time of tight expenditures and so on, if you are not sure that the date is firm, that is causing many people to postpone doing the final preparation to be ready, and so yet another delay, frankly, if we go to a third delay, I don't believe the industry is going to believe that we will ever move forward, and the transition will become that much more difficult if and when it ever occurs.

So after two delays—and I just want to point out, the original proposed rule on I-10 was 2011. Then based on public comments, it was moved to 2013, and then we have had our two delays that have occurred subsequently.

And so it is the uncertainty of the date that is causing the major problems out there in the industry to be absolutely at the end of the day prepared for a smooth transition.

Mr. PALLONE. Thank you. Thank you, Mr. Chairman.

Mr. PITTS. Thank you to each of the witnesses. Excellent testimony, very informative, very important.

We will have follow-up questions from members, those who weren't able to attend. We will send those to you in writing. We ask that you please respond promptly.

I remind members that they have 10 business days to submit questions for the record. The members should submit their questions by the close of business on Thursday, February 26th.

So with thanks to our panel, without objection, the subcommittee is adjourned.

[Whereupon, at 12:31 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Today the subcommittee will examine the implementation of ICD-10—the latest coding system for healthcare providers to use for reimbursements and other purposes—set to happen on October 1st of this year. Today's hearing is an opportunity to learn more about what ICD-10 is, how it can help patients and our healthcare system, and whether stakeholders are prepared for its implementation later this year.

The United States is one of the few countries that has yet to adopt this most modern coding system. Australia was the first country to adopt ICD-10 in 1998. Since then, Canada, China, France, Germany, Korea, South Africa, and Thailand—just to name a few—have all also implemented ICD-10. In the United States, Congress, through one vehicle or another, has prevented the adoption of ICD-10 for nearly a decade.

Under law, ICD-10 is set to become the coding system of the United States on October 1, 2015. Understanding that the reasons for delay in the past have been credited to preparedness, today we look forward to hearing from the witnesses on their plans for implementing ICD-10 later this year.

I thank the witnesses for their testimony and recommendations.



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**Statement
of the
American Hospital Association
before the
Health Subcommittee
of the
Committee on Energy and Commerce
of the
U.S. House of Representatives**

“Examining ICD-10 Implementation”

February 11, 2015

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment for the record as part of the Subcommittee’s assessment of the health care community’s readiness to complete the transition to ICD-10 on Oct. 1, 2015. The AHA strongly supports the Oct. 1, 2015 ICD-10 compliance date and opposes any steps to delay this implementation date.

HEALTH CARE NEEDS A MODERN CODING SYSTEM

In 2009, the Department of Health and Human Services (HHS) issued a final rule to update ICD-9-CM to ICD-10-CM for diagnosis coding and ICD-10-PCS for procedure coding (jointly referred to as ICD-10).¹ The federal government has delayed the transition, first proposed for Oct. 1, 2011, a number of times. Most recently, in March 2014, Congress enacted a provision in the Protecting Access to Medicare Act that prevented HHS from implementing ICD-10 on Oct. 1, 2014, as planned, and required at least a one-year delay. HHS has since issued a final rule requiring all providers, payers and clearinghouses to be ready by Oct. 1, 2015.

The AHA has supported the statutory requirement that hospitals transition to the ICD-10 classification systems for clinical diagnoses and procedures because they provide needed



modernization of coding and billing systems. While it entails significant effort and cost, the move to ICD-10 is important to ensure payment accuracy and deepen our understanding of health care delivery.

ICD-10-CM is an upgrade to the current, outdated diagnosis coding system. Diagnosis codes are a way for hospitals, physicians and other providers to efficiently and electronically exchange information with health plans to describe patient conditions. They are embedded in nearly every health care clinical and billing operation nationwide. Diagnosis codes describe patients' conditions, justify the services provided and demonstrate medical necessity. ICD-10-PCS is the companion procedure coding system that will affect only hospitals reporting inpatient procedures.

The expanded granularity of the ICD-10 codes will allow health care providers and payers to better distinguish newer technologies and resource differences. Enhancements include the ability to differentiate surgical approaches, anatomical regions and devices. In addition, the move to ICD-10 will allow caregivers to include more detail on socioeconomic factors, family relationships, ambulatory care conditions, problems related to lifestyle and the results of screening tests. It also will mean better data to monitor resource utilization, improve clinical, financial and administrative performance, and track public health risks. For example, under hospital pay-for-performance programs such as the readmissions penalties and hospital-acquired conditions penalties, it is important to describe fully the nature of a patient's condition. More detailed coding systems also will improve the nation's understanding of the diseases or illnesses being treated and will provide caregivers and the public with better information to guide future treatment.

Together, the diagnosis and procedure codes are the DNA of diagnosis-related groups (DRGs), which are used by Medicare and other payers for reimbursing hospitals for inpatient care. While physicians must include the diagnosis codes on their claims for purposes of benefit determination, health plans generally do not use the diagnosis codes to determine physician payment amounts. Physicians and hospital outpatient departments will continue to use Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System codes (HCPCS) and be paid based on those codes. That said, all parties must move to ICD-10 at the same time or billing systems will not work correctly, leading to widespread confusion and disruptions in payments.

WHY SO MANY CODES?

Under ICD-10, the coding system will grow significantly, and many have expressed concern over the number of codes. However, ICD-9 is more than 30 years old, and has simply "run out of room." Despite annual revisions, it is not able to keep up with changes in medical knowledge or the demands for detailed administrative data to evaluate the quality of care, implement value-based purchasing, and support biosurveillance and public health initiatives. For example, ICD-9 does not have room for a specified code for Ebola; rather, it includes Ebola along with other conditions in a code titled "other specified diseases due to viruses." By contrast, ICD-10 has a specific code for Ebola. Furthermore, due to current numbering constraints, distinct procedures performed on different parts of the body and with widely different resource utilization are

grouped together under the same procedure code. In addition, ICD-9 cannot distinguish between surgery performed on the right side of the body versus the left – a flaw that is corrected in ICD-10 and partly responsible for the large increase in the number of codes.

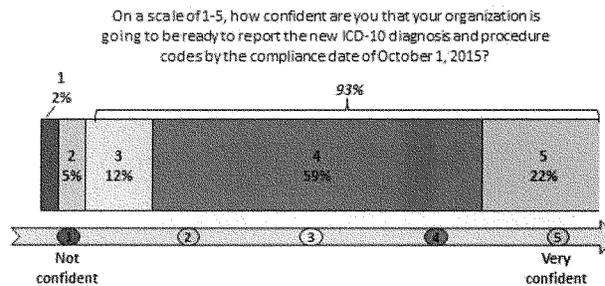
Other important changes, such as the identification of chronology of encounters for injuries (e.g., initial, subsequent or treatment of related long-term adverse consequence) have a significant impact on the number of codes, but are simple and important concepts for communicating about a patient’s condition. As noted in media reports, some of the new codes are esoteric, such as being bitten by a shark, and pertain to very rare instances. However, these codes may be relevant to occupational hazards, public health concerns or other risks that medical specialty societies have requested. In practice, of course, all of the codes do not need to be learned by all physicians, but can be looked up when needed for a specific patient in a rare incident, such as an employee of an aquarium attacked by a shark while on the job.

The ICD-10 coding system supports advances in medicine by allowing groups and individuals to request new codes, such as a code for a new technology or a differentiated diagnosis that allows for more accuracy. Over the past three years, the ICD-10 Coordination and Maintenance Committee has received requests for almost 1,500 new codes. Of those requests, fully 95 percent came from physician specialty societies. Thus, while some physician groups have expressed concern over the number of codes in ICD-10, it is clear that many physician groups understand the need for a modern coding system.

HOSPITALS ARE READY FOR ICD-10

Hospitals widely report they will be ready to submit claims using ICD-10 by the scheduled implementation date of Oct. 1, 2015. In a January/February 2014 survey of more than 360 hospitals conducted by the AHA, more than nine out of 10 hospitals responded that they were moderately to very confident of meeting the deadline (Figure 1), while more than 85 percent of critical access hospitals expressed confidence in their ability to report claims under ICD-10 by Oct. 1, 2015.

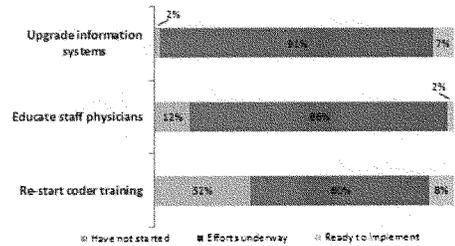
Figure 1. 93% of hospitals indicate they are moderately to very confident they will be able to report under ICD-10 by October 2015.



Source: AHA survey of 362 hospitals conducted in Jan. and Feb. 2014.

Hospitals are actively preparing their information systems, affiliated physicians and coders to make the transition possible (Figure 2). Members have told us, however, that the one-year delay has cast some uncertainty over their plans, and they need firm commitment that Oct. 1, 2015 is the transition date so that they can plan with confidence.

Figure 2. Hospital Preparations for October 1, 2015 Transition to ICD-10 are Underway



Source: AHA survey of 362 hospitals conducted in Jan. and Feb. 2014.

Hospitals are actively engaged with their many information services

vendors to ensure that the dozens of systems that will be impacted by ICD-10 are upgraded on time, and fully 98 percent of hospitals have these efforts underway or completed.

There is a strong commitment by hospitals to actively work on physician engagement by providing educational training and documentation improvements that are complete and accurate. Almost 90 percent of hospitals have physician education efforts underway or completed. Generally physicians will not need to know the specific ICD-10 codes, but they will need some familiarity with new coding concepts, such as the need to reference the right or left side of the body (called laterality), and the inclusion of narrative within the documentation that ensures the right code choice.

Many hospitals have conducted staff training for ICD-10 over multiple years to prepare for the conversion. Coding of trainers is time-consuming and expensive, and must be repeated if the implementation date changes. Because of last year's delay, hospitals currently are gearing up to repeat training that had already been underway. Almost 70 percent of hospitals once again have coder training underway or completed. Hospitals also are working with both public and private-sector payers to conduct testing. While hospitals are taking the needed steps to prepare for ICD-10, they also must have the collaboration of their many partners, including physicians, vendors and payers.

ANY FURTHER DELAY WILL BE COSTLY

Hospitals and physicians have had sufficient advance warning of the transition date for ICD-10. Hospitals have been preparing for ICD-10 for three years with the understanding that it will be a challenge, but must be accomplished, and can be accomplished if all parties work together. Recent experience demonstrates how costly delay can be, and why we must avoid any further delay.

The one-year delay has been disruptive and costly for hospitals and health systems, as well as to health care delivery innovation, payment reform, public health and health care payment. Significant investments were made by hospitals and health systems to prepare for the October 2014 implementation date, many of which are now being duplicated. For example, training programs must be repeated, information systems must be updated anew, and hospitals are maintaining both the old and new coding systems for longer than expected. Additionally, there were consulting contracts that had to be extended, reworked and repeated for a later date. The Centers for Medicare & Medicaid Services (CMS) estimated that the delay cost health plans, Medicare, Medicaid, hospitals and large providers between \$1.2 billion (low estimate) and \$6.9 billion (high estimate).ⁱⁱ

The delay also disrupted operations. Many of our members had to quickly reconfigure systems and processes that were prepared to use ICD-10 back to ICD-9. Newly trained coders who graduated from ICD-10 focused programs were unprepared for use of the older code set and needed to be retrained back to using ICD-9. Efforts invested in ICD-10 took away from other activities, such as delivery system reform. Any further delay will only add additional costs as existing investments will be further wasted and future costs will grow.

Once the Oct. 1, 2015 date was finalized by HHS, hospitals once again began to ramp up their preparations. The AHA and hospitals are working with HHS to ensure a smooth and successful transition in 2015. We support the recently announced end-to-end testing dates issued by CMS and are encouraging our members to participate in these opportunities. We also have encouraged CMS to make as much testing available as possible. As noted in a recent report by the United States Government Accountability Office, “CMS has taken multiple steps to help prepare covered entities for the transition, including developing educational materials and conducting outreach.” In addition, our hospital members are engaging in significant efforts to be ready for the Oct. 1, 2015 implementation date, including supporting their affiliated physicians, working with their payers, and conducting training and outreach initiatives for clinicians and coders.

ICD-10 is needed now to keep up with advances in medicine and ensure accurate payment. Uncertainty over the possibility of any additional delay casts a long shadow over current preparations. In order to achieve a successful transition to ICD-10, the entire health care community – hospitals, physicians, payers, clearinghouses and government agencies – must stop debating the value of ICD-10 and take the needed actions to implement it successfully. We urge Congress to stop any proposal to further delay this needed coding update.

ⁱICD-10-CM stands for International Classification of Diseases, 10th Revision, Clinical Modification and ICD-10-PCS stands for International Classification of Diseases, 10th Revision, Procedure Coding System.

ⁱⁱ HHS. Administrative Simplification: Change to the Compliance Date for the International Classification of Diseases, 10th Revision (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets. Final Rule. *Federal Register*, Aug. 4, 2014.

February 11, 2015

The Honorable Joe Pitts
 Chairman
 Health Subcommittee
 Energy and Commerce Committee
 U.S. House of Representatives
 Washington, DC 20515

The Honorable Gene Green
 Ranking Member
 Health Subcommittee
 Energy and Commerce Committee
 U.S. House of Representatives
 Washington, DC 20515

Dear Chairman Pitts and Ranking Member Green:

The Coalition for ICD-10, a broad constituency of organizations from across the health care spectrum, thanks you for holding this hearing today on ICD-10 adoption. A number of our coalition partners will be testifying today to tell the Committee: **We need ICD-10, and we're ready.**

As you know, the Coalition for ICD-10 (<http://coalitionforicd10.org/>) is a broad-based healthcare industry group, including hospitals, health plans, hospital and physician office coding experts, physician office managers, vendors, medical device manufacturers, and the health informatics and information technology (HIT) community. We are all united in strong support of the U.S. implementation of the scheduled October 2015 implementation of the ICD-10 coding standard. We all strongly oppose any steps to delay this implementation date.

We need ICD-10. As representatives of the majority of the health care sector, we believe that ICD-10 is a long overdue replacement for the outdated ICD-9-CM system for reporting diagnosis and procedure information. ICD-9 lacks adequate information to establish fair payment and judge quality. The reality is with ICD-9 we often don't know what really wrong with the patient or what procedures were performed. Often ICD-9 does not allow us to establish fair payment levels, evaluate outcomes, or understanding complication rates.

We need a modern code set to reflect the advances of our innovative and modern health care system. As efforts are made to reform health care reimbursement to reward value over volume, we need ICD-10. If we are to rate hospitals and physicians based on their outcomes, we need ICD-10. If we are to better assess what procedures, technologies, or approaches best aid improving patient care, we need ICD-10. ICD-10 also allows us to better respond to health or national security threats with codes that better allow us to track pandemics, epidemics, and other threats. ICD-10 improves patient safety and care with severity of illness information that can help assess population health and create disease prevention models.

We are ready. ICD-10 implementation delays have been disruptive and costly for all of the coalition members, as well as to health care delivery innovation, payment reform, public health, and health care spending. Significant investments were made by members of our coalition to prepare for the October 2014 implementation prior to enactment of the most recent delay. Many of us had to quickly reconfigure systems and processes that were prepared to use ICD-10 back to

ICD-9. Newly trained coders who graduated from ICD-10 focused programs were unprepared to find jobs using the older code set.

HHS has estimated the cost of the most recent delay at \$6.8 billion; further delays beyond October 1, 2015 range from \$1 billion to \$6.6 billion in additional costs. Nearly three quarters of the hospitals and health systems surveyed just before the current delay were confident in their ability to successfully implement ICD-10. Retraining personnel and reconfiguring systems multiple times in anticipation of the implementation of ICD-10 is unnecessarily driving up the cost of healthcare.

Coalition members are working together and with HHS to ensure a smooth and successful transition in 2015. We support the end-to-end testing being done by CMS and are encouraging all of our members to participate in these opportunities. In addition, members of our coalition are engaging in significant efforts to identify and educate those in need of assistance to be ready for the 2015 implementation, including payer-provider collaboratives, training and outreach initiatives, and programs to help coders maintain their new code set skills.

We thank the Committee again for its focus on this important issue. We urge the Committee to avoid any further delays of this needed coding update. We look forward to working with you to ensure a smooth transition to this critically needed coding upgrade.

Sincerely,

The Coalition for ICD-10

cc:
The Honorable Fred Upton
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Coalition for ICD-10 Members:
(<http://coalitionforicd10.org/about>)

3M Health Information Systems
Anthem
Advanced Medical Technology Association (AdvaMed)
Altegra Health
America's Health Insurance Plans (AHIP)
American Health Information Management Association (AHIMA)
American Hospital Association (AHA)
American Medical Billing Association (AMBA)
American Medical Informatics Association (AMIA)
Beyer Medical Group
BlueCross BlueShield Association
College of Healthcare Information Management Executives (CHIME)
Health IT Now Coalition
Healthcare Financial Management Association (HFMA)
Healthcare Leadership Council
Leidos Health
Medical Device Manufacturers Association (MDMA)
Medtronic
Nemours Children's Health System
Premier
Professional Association of Health Care Office Management (PAHCOM)
Roche Diagnostics Corporation
Smith & Nephew



Statement for the Record

Submitted by

The Premier healthcare alliance

Examining ICD-10 Implementation

House Energy and Commerce Subcommittee on Health

February 11, 2015

The Premier healthcare alliance appreciates the opportunity to provide a statement for the record on the House Energy and Commerce hearing, titled "Examining ICD-10 Implementation." Premier, Inc. is a leading healthcare improvement company, uniting an alliance of approximately 3,400 U.S. hospitals and 110,000 other providers to transform healthcare. With integrated data and analytics, collaborative, supply chain solutions, and advisory and other services, Premier enables better care and outcomes at a lower cost. Premier, a Malcolm Baldrige National Quality Award recipient, plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. We applaud the leadership of Chairman Rep. Joe Pitts and Ranking Member Frank Pallone, Jr. for holding this important hearing today.

Premier healthcare alliance strongly supports the October 1, 2015, implementation deadline for the 10th revision of the International Classification of Diseases (ICD-10) codes. Our member hospitals are and will be ready by the implementation date, and oppose any steps to delay the implementation date.

As a member of the ICD-10 Coalition, which is made up of a broad constituency of organizations across the healthcare spectrum, our survey findings indicate that **over three quarters of America's hospitals and health systems, including the majority of Premier member hospitals, have been ready to successfully implement ICD-10 since last year.** Our findings also indicate the recent delay of ICD-10 implementation (for the third time) has been very disruptive and costly for hospitals and health systems, as well as to healthcare delivery innovation, payment reform, public health, and healthcare payment. Significant investments have already been made by the healthcare community, including Premier member hospitals, to prepare

for the October 2014, implementation prior to enactment of the most recent delay. Due to the delay, many of our member hospitals had to quickly reconfigure systems and processes that were prepared to use ICD-10 back to ICD-9. For example, newly trained ICD-10 coders were unprepared for use of the older code set and needed to be retrained back to using ICD-9. Furthermore, training of existing coders needed to be repeated given the one-year delay. This resulted in the doubling of costs that are wasteful and unproductive. The Department of Health and Human Services (HHS) estimates that the most recent ICD-10 delay cost \$6.8 billion and any further delays beyond October 1, 2015, could range from \$1 billion to \$6.6 billion in additional costs.

The Centers for Medicare & Medicaid Services (CMS), is also ready for ICD-10, as the recent GAO report found.¹ The GAO found that CMS has steadily undertaken a number of efforts to prepare for the October 1, 2015, implementation deadline internally and with the stakeholders. For instance, CMS has completed modification of its Medicare systems and policies, completing all ICD-10-related changes to its Medicare fee-for-service (FFS) claims processing systems. GAO findings also indicate that CMS has conducted consistent outreach to stakeholders for the move to ICD-10, including in-person training sessions, teleconferences, educational materials, and monitoring the readiness of providers and payers, as well as external testing, which they plan to continue as the October 1, 2015 approaches.

As this Committee is well aware, the cost to any further delays in ICD-10 is not only wasteful from a dollar and resource perspective but has serious implications on quality and cost improvements, population health management, and the tracking and surveillance of pandemic threats like Ebola. At this point, ICD-9 cannot capture such pandemic indications, unlike the more adaptive and effective code sets such as ICD-10. In fact, the implementation of ICD-10 will allow for more precise diagnosis and procedure codes, resulting in the improved capture of health care information and more accurate reimbursements. For instance, some of the key benefits of ICD-10 include²:

- Improved ability to measure health care services, including quality and safety data;
- Augmented sensitivity when refining grouping and reimbursement methodologies;
- Expanded ability to conduct public health surveillance;
- Decreased need to include supporting documentation with claims;
- Strengthened ability to distinguish advances in medicine and medical technology;
- Enhanced detail on socioeconomic, family relationships, ambulatory care conditions, problems; related to lifestyle and the results of screening tests;

¹ <http://www.gao.gov/products/GAO-15-255>.

² <http://www.ahacentraloffice.org/codes/ICD10.shtml>

- Increased use of administrative data to evaluate medical processes and outcomes, to conduct biosurveillance and to support value-based purchasing initiatives.

We thank the Committee again for holding this important hearing today. As discussed previously, the stakeholders and CMS are ready for ICD-10 by October 1, 2015. We urge Congress to avoid any further delays in ICD-10 implementation, which is needed to keep up with advances in medicine and more accurate health information and payment. If you have any questions or comments, please contact Lauren Choi, senior director of Federal and International Affairs at Premier, Inc. Lauren_choi@premierinc.com or 202.879.8005.



Statement

of the

American Medical Association

to the

**Committee on Energy & Commerce
Subcommittee on Health
United States House of Representatives**

Re: Examining ICD-10 Implementation

February 11, 2015

**Division of Legislative Counsel
(202) 789-7428**

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Statement

of the

American Medical Association

to the

Committee on Energy & Commerce
Subcommittee on Health
United States House of Representatives

Re: Examining ICD-10 Implementation

February 11, 2015

The American Medical Association (AMA) appreciates the Energy & Commerce Committee, Subcommittee on Health for conducting this hearing to examine the implementation of the International Classification of Diseases, Tenth Revision (ICD-10) code set.

In the United States every health care claim submitted by physicians and other health care providers for reimbursement currently relies on ICD-9 codes. ICD-9 codes are also the standard used for documenting patient medical diagnoses and inpatient medical procedures, which implicates quality reporting, population health, as well as many other research and reporting activities. The transition to ICD-10 therefore represents one of the largest technical, operational, and business implementations in the health care industry in the past several decades. The following outlines key concerns that the AMA believes the Subcommittee should consider as it examines and prepares for the October 1, 2015 transition deadline.

Testing

The AMA appreciates the training, educational tools, and other efforts by the Centers for Medicare & Medicaid Services (CMS) to prepare physicians and other health care entities for the ICD-10 transition.

Yet despite these efforts, there still remains a lack of industry-wide, thorough end-to-end testing of ICD-10 in administrative transactions.

CMS conducted acknowledgement testing of claims for one week in March and November 2014 and additional weeks are planned in March and June 2015. Acknowledgement testing, however, only tests that the claim will be initially accepted through the claims processing system. It provides no information about if and how the claim will process completely, ensuring payment to physicians.

Results of this acknowledgement testing were also limited, with acceptance rates ranging from 89 percent to 76 percent. In comparison, the normal acceptance rate for Medicare claims is 95 – 98 percent. Given that Medicare processes 4.4 million claims per day, even a small change in this acceptance rate will have an enormous impact on the system and payment to physicians. CMS also failed to explain in detail the errors that were encountered and what steps need to be taken to correct these problems.

After significant requests from stakeholders, CMS agreed to conduct more robust end-to-end testing in which the claim will be accepted, processed, and a remittance advice generated. The first week of testing was done the last week of January 2015; yet, to date, no information has been released about the results of this testing. Additional weeks of testing will occur in April and July 2015. While we believe CMS has taken a step in the right direction, this process is still severely limited—testing with 850 claims submitters per testing week for a total of 2,550 testers, a small fraction of all Medicare providers.

Moreover, this testing is only focused on Medicare and fails to include or estimate the problems that are likely to occur with private insurers and other payers. While not every physician or other health care provider can test with all of its payers, the industry needs widespread, comprehensive testing and sharing of detailed results before the implementation deadline. Yet, neither of these has occurred to date.

Quality Measurement

In addition to claim processing, questions remain about the ability to correctly collect and calculate quality data during and after the transition to ICD-10. While CMS has stated that quality measures have been specified for ICD-10, we foresee unintended consequences for measure denominators and measure rates due to potentially conflicting timelines. ICD-10 is scheduled to begin on October 1, 2015, but the Physician Quality Reporting System (PQRS) reporting period is based on the calendar year (Jan. 1- Dec. 31, 2015). Many of the PQRS measures capture encounters pre and post visit and will straddle the October 1 date, requiring that physicians report ICD-9 for the first segment and ICD-10 for the final portion. Though the AMA has communicated our concerns to the agency regarding quality measurement, CMS has not announced its policy to address how it will handle this change.

We are also concerned about the effects of ICD-10 on Value Based Modifier (VBM) measures, as measure calculations and associated costs will vary depending upon the utilization of ICD-9 or ICD-10. In part, the VBM formula compares how providers perform from year-to-year. Accordingly, transitioning the VBM program to the more granular ICD-10 system could significantly alter how measures are scored between the baseline and performance periods. Similarly, commercial payers also have quality reporting systems that impact physician reimbursement and ratings and are likely to be affected by the code set change.

Despite the importance of these efforts, the Medicare end-to-end testing is not expected to test the impact on quality measurement or Medicare's ability to properly calculate measures. We also believe that commercial payers may not have thoroughly evaluated and tested how the ICD-10 transition will affect quality measurement and reporting.

Risk Mitigation during Transition

Previous implementations of Health Insurance Portability and Accountability (HIPAA) requirements—such as the National Provider Identifier and upgrade to Version 5010 transactions—resulted in claims not processing and physicians going unpaid for weeks and sometimes months. These implementations required significantly less changes than ICD-10 and still resulted in significant payment delays that jeopardize practices.

Based on these past experiences, the AMA has asked that CMS outline detailed risk mitigation strategies to protect against any similar implementation challenges. In particular, we have asked CMS to make use of its Advanced Payment Policy that could mitigate situations where a physician is unable to be paid due to the code set change. This policy would go into effect when a physician has completed services and submitted claims, but for some reason Medicare is unable to process them. Money paid in advance as a result of a Medicare system issue would be recouped from payments once the problems are resolved and claims begin processing. To date, insufficient efforts have been made by CMS to ensure advanced payments will be widely available to physicians who experience serious claims processing challenges. We are concerned that without this and other risk strategies, CMS may be caught off-guard without feasible remedies for patients and physicians.

Cost

In 2008, the AMA enlisted Nachimson Advisors to conduct a study on the costs of ICD-10 implementation. That study estimated that the code change would cost approximately \$83,290 for a small physician practice up to \$2,728,780 for a large practice. Since that time, the industry has gained actual experience with implementing the new code set, providing more accurate data on the costs of this transition. In February 2014, the AMA released an updated cost study that reevaluated the implementation of ICD-10 on physician practices. The costs were found to be nearly three times higher than initial estimates in 2008—ranging from \$56,519 for a small practice up to over \$8 million for a large practice.

These total costs include the expense of training, practice assessments, testing, vendor/software upgrades, payment disruptions and productivity loss for physicians. In particular, coding in ICD-10 will take longer, which will translate to a significant decrease in productivity. Studies on ambulatory settings suggest a 10 percent decrease, while hospital performance shows a nearly 50 percent drop in productivity.

While other studies have tried to assess the cost of ICD-10, we are concerned that they omit critical steps in the implementation process, including planning, assessment, internal testing and documentation assessment. These lower estimates also assume a zero cost for technology; in contrast, our members have incurred significant costs for software upgrades and other vendor expenses.

Conclusion

By itself, the implementation of ICD-10 is a massive undertaking. The AMA remains gravely concerned that many aspects of this undertaking have not been fully assessed and that contingency plans may be inadequate if serious disruptions occur on or after October 1. Furthermore, physicians are being asked to assume this significant change at the same time that they are being required to adopt new technology, re-engineer workflow, and reform the way they deliver care—all of which are challenging their ability to care for patients and make investments to improve quality.

We urge that the Subcommittee recognize the challenges related to ICD-10, not in isolation, but as part of this broader health care environment. It is vitally important that CMS and other payers are prepared with extensive contingency plans in the event that these feared disruptions occur. Such contingency plans include further delaying the implementation timeline, allowing claims to be submitted using ICD-9 codes until all systems are properly functioning, and providing advance payments to providers to compensate for claims processing delays.

The AMA appreciates the opportunity to provide our comments on implementing ICD-10, and we look forward to working with the Subcommittee and Congress on this important health care issue.

House Energy & Commerce Subcommittee on Health
Hearing: Health Care Coding System Implementation

February 11, 2015

American Academy of Dermatology Association

Statement for the Record

Chairman Pitts and Ranking Member Green, the American Academy of Dermatology Association (Academy), which represents nearly 13,500 dermatologists nationwide, commends you for holding a hearing about the state of preparedness for International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10) as the implementation date of October 1, 2015 will soon be upon us. The Academy is committed to excellence in medical and surgical treatment of skin disease; advocating high standards in clinical practice, education, and research in dermatology and dermatopathology; and supporting and enhancing patient care to reduce the burden of disease. We applaud you for raising awareness of the needs of physicians and other health care providers to ensure that as we continue to move forward in health care technology we make sure that our member physicians are ready for the ICD-10 implementation, while also ensuring that patients are receiving high-quality, efficient care.

For more than 30 years, physicians have been describing the diagnoses and inpatient procedures for the care they deliver to their patients with the International Classification of Diseases, Ninth Edition (ICD-9). ICD-9 initially was used primarily in the hospital inpatient setting for indexing purposes, and was not designed to be used for reimbursement purposes. As the ICD-9 became an ingrained body of knowledge for physicians, its use changed. While not perfect, ICD-9 was able to capture sufficient data about diagnoses to inform new prospective payment policies. Soon the use of ICD-9 spread from hospital inpatient settings, to outpatient settings.

ICD-10 is significantly more complex and voluminous than ICD-9. Further, it restructures the diagnosis classification system with far more alpha numeric codes, expanded code lengths, and narrative descriptions. While ICD-10 has the potential to capture a deeper level of diagnostic information than its predecessor, the move to ICD-10 for a specialty like dermatology, which has 900 codes in the ICD-9 system, will be an incredibly large and complex undertaking, as there are over 2,200 ICD-10 codes for dermatology alone. Our members are not only concerned about this transition but also the fact that ICD-10 is cumbersome and expensive; further, our members are concerned ICD-10 will not necessarily improve patient care while adding more paperwork to an ever-increasing burden of regulatory complexity and reporting. To be ICD-10 ready, dermatologists and their practices will need to become conversant in this new classification system, as ICD-10 drills down to a level not contemplated by ICD-9. For example, more than 20 commonly seen rashes are listed under ICD-9 under the single code, "dermatitis unspecified," but each are delineated by distinct codes in ICD-10.

The costs to implement ICD-10 are not insignificant. According to the AMA's February 2014 report, "The Cost of Implementing ICD-10 for Physician Practices – Updating the 2008 Nachimson Advisors Study," the costs have gone up tremendously since 2008. Approximately sixty percent (60%) of U.S. dermatologists are in small or solo group practices. Nachimson estimated in 2008 that the cost of ICD-10-CM implementation for the typical small practice would be \$83,290. In 2014, Nachimson estimated that the total implementation cost for the typical small practice would be between \$56,639 and \$226,105. While the 2014 study provided

a range estimate, it did find that the majority of small practices must pay for system upgrades, for which there are significantly higher costs in 2014 than in 2008. The pre-implementation costs of \$25,560-\$105,506 include expenditures for training, assessment, vendor/software upgrades, process remediation and testing. The post-implementation costs of \$31,079 to \$120,599 include estimates for productivity loss and payment disruption. The Nachimson study estimates that physicians in small practices will spend an additional 4% of their time to perform documentation under ICD-10-CM and an additional 1% for coding.

The American Academy of Dermatology Association collaborated with the American Medical Association (AMA) and other specialty societies for a successful delay of ICD-10 implementation from October 1, 2013 to October 1, 2014. The Academy then appreciated the further implementation delay to October 1, 2015. Now, the Academy believes that further delay would be desirable and helpful to our members, and also beneficial for patient care. While the Academy is also prepared to continue to help our members' transition to ICD-10 if this is mandated, the complexity and expense of the transition are substantial and the Academy does not see any urgent need for rapid transition. Delayed transition would not impact patient care unfavorably, nor would it decrease physician office efficiency, and nor would it save scarce healthcare dollars. On the contrary, the transition is a distraction from the real challenges facing dermatologists in ensuring patient access to cost-effective care. ICD-10 implementation diverts limited resources to a low priority goal. It actually increases practice costs on an ongoing basis, as more practice time is diverted to coding.

Some have suggested that ICD-10, which is more than a decade old, has many limitations and will soon be obsolete. In light of this, many physicians have advocated that a more useful transition would therefore be to ICD-11, which is under development. The AADA has not taken a formal stance on this, but is considering whether this is necessary given the many other structural changes occurring in the physician practice environment.

We appreciate your continued leadership on this issue and look forward to working with you to ensure that physician practices are ready for ICD-10 implementation, if this is required, or to delay or modify the transition, if this is possible. The Academy would like to serve as a resource for you and your subcommittee, as you continue to address this important issue. If you have questions, or if we can provide any additional information, please contact Christine O'Connor, Associate Director, Congressional Policy at (202)609-6330 or coconnor@aad.org.



“Examining ICD-10 Implementation”

Testimony of Dr. Fred Azar

President, American Association of Orthopaedic Surgeons

House Committee on Energy and Commerce

Subcommittee on Health

Wednesday, February 11, 2015, 10:15 a.m.

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On behalf of the American Association of Orthopaedic Surgeons (AAOS), which represents over 18,000 board-certified orthopaedic surgeons, I would like to express our grave concern about the transition from the current International Classification of Diseases, version 9 (ICD-9) to ICD-10. This transition will be prohibitively costly to implement and will detract from patient care with very little benefit to the public health system.

The differences between ICD-9 and ICD-10 are substantial. The ICD-10 diagnosis set has 68,000 codes – a five-fold increase from the approximately 13,000 diagnosis codes currently in ICD-9 CM and the ICD-10 professional set, ICD-10 PCS, used for hospital procedure coding) has over 100,000 codes, a five-fold increase as well. This issue of expansion is particularly important to orthopaedics and musculoskeletal care whereas ICD-10 CM has more than 30,000 musculoskeletal codes and ICD-10 PCS has more than 45,000 orthopaedic and musculoskeletal codes. These numbers are too large for any sized practice to easily implement. Thus, the transition to ICD-10 will have a more negative impact on orthopaedics than any other physician specialty.

There are four main problems with implementing ICD-10 at this time:

- 1) ICD-10 is overly complex
- 2) It will be costly to implement
- 3) It will decrease physician productivity and patient access to care
- 4) It's poor timing – there are too many changes occurring at this time

Complexity of ICD-10

There are thousands and thousands of codes – more than any other country in the world has in their version of ICD-10. Ours will be the only country which uses ICD-10 for billing purposes. The system will be onerous.

There are many rules and peculiarities which make it difficult to learn and use. For instance:

Sometimes a tendon rupture is a disease and sometimes it's an injury but it's not called a "rupture", it's a "strain".

An open fracture is the term used when the skin and soft tissues are damaged over a fracture and the bone is exposed. For many bones, there are specific codes for the open fracture – like open fracture of femur. For other bones, there is no open fracture code and

one must use two codes – one for the fracture and one for the associated open wound. One has to learn to master the inconsistencies.

Osteonecrosis is a term which describes localized bone death. It often affects the hip or knee. In ICD-10 there is no code for osteonecrosis of the hip or knee – there is only a code for the femur which really poorly localizes the problem.

ICD-10 incorporates a 7th character which more or less describes the status of treatment. In other words the ICD-10 code for a condition changes over time. This is a strange concept to current physicians and coders and must be learned. It is not clear how this is helpful to patients or professionals.

For the medical professional, it won't be possible to wake up on the morning of October 1st 2015 and practice business as usual. It will be necessary to spend hours of preparation putting the system of ICD-10 in place and learning how to use it.

Cost of Implementation

The estimated implementation cost of ICD-10 is between \$83,000 and \$2.7 million, depending on the size of the practice (Nachimson Advisors).

Each physician and other professionals in the practice will need to take off work to attend ICD-10 training. This results in a cost for purchasing the training and the additional cost of lost productivity. These are all expenses which will not be reimbursed.

Each practice will need to purchase ICD-10 books, training manuals and software to use the system. There's too much to commit to memory – practices will need to have specific references.

Many physicians have a small enough scope of practice that each can currently bill for a patient encounter on a single sheet of paper called a "superbill". The physician simply checks off a diagnosis and a treatment and billing is complete. In ICD-10, there are too many codes for a single superbill. Each physician practice will likely need an electronic system of billing which means new hardware and billing software. These changes will require time and money.

Physicians who use third party billers or clearing houses will need to revamp their systems.

All of these changes will cost the physician time and money. This amounts to an unfunded mandate.

Decrease in Physician Productivity – Decrease in Patient Access

Because of the increased granularity in ICD-10 it is going to take more time for the physician to document the specific detail required to arrive at the correct ICD-10 code and more time to choose the right code than it has in the past. More time per patient means, fewer patients per day, which means a decrease in productivity. Decrease in productivity results in decreased access to patient care.

Canada is our close friend and neighbor. When the Canadian healthcare system adopted ICD-10, there was an immediate drop in productivity of 30%. Productivity improved over time but never fully returned to pre-ICD-10 levels. It doesn't seem like our health care system can afford a hit like this.

In addition to decreased productivity is the added cost of denied claims. It is anticipated that early on in the transition to ICD-10, a significant percentage of claims will be denied or held back for payment. The AAOS has been advising orthopaedic practices to take out a line of credit equal to 6-months revenue at the beginning of the ICD-10 transition in anticipation that revenues will drop suddenly and precipitously as a result of the transition. This is a financial burden that many practices cannot sustain. In addition, orthopaedic practices will face tremendous burdens in verifying patient eligibility, obtaining pre-authorization for services, documentation of the patient's visit, research activities, public health reporting and quality reporting. Physicians who are unable to transition to ICD-10 by the implementation date simply will not get paid. All of these changes are made in order to transition to a code set that provides no patient care benefits nor physician reimbursement to offset these added costs.

Bad Timing

Physicians in the USA are already reeling from several administrative changes affecting the practice of medicine. These include the many changes detailed in the Affordable Care Act, requirements for Meaningful Use of EMR, Value-Based reporting, unpredictability in the SGR, e-prescribing and the recent plans by CMS to eliminate 10 and 90 day global payments to physicians. The additional burden of converting to ICD-10 on 1 October 2015 is over the top.

Finally, despite the huge expansion in the number and specificity of ICD, the codes still need significant refinement. The AAOS has actively been working to update the ICD-10 CM and ICD-10 PCS systems but there are still significant gaps that need to be addressed before implementation.

Summary

ICD 10 is a great system as it has been adopted by other first world nations. A great deal of work has gone into its development. Its use in studies of epidemiology may prove useful. In countries outside the United States where ICD 10 is used, the burden of implementation and documentation is borne by the government. The volume of codes is relatively small. The volume of codes in the system about to be adopted in the United States is greater than that in any other country in the world. The burden and expense of using the system is going to be born entirely by physicians, yet there is no clear benefit to physicians. There is no clear benefit to patient care, either. It is not clear that explosive and disruptive effects brought about by the implementation of ICD-10 on October 1st will be outweighed by an improvement in patient care

We are concerned that implementing ICD-10 will detract from patient care with very little benefit. According to the American Health Information Management Association and eHealth Initiative Survey, many respondents think coding, documenting patient encounters and adjudicating reimbursement claims will be harder under the new system. All of these issues inhibit the doctor-patient relationship, which is critical to quality care.

We believe that prohibiting the transition to ICD-10 will enable physicians and other stakeholders to assess an appropriate alternative to such a burdensome, regulatory requirement and help reduce costs weighing on physician practices, as well as help to keep new, more efficient models of health care delivery and payment on track. In the absence of prohibition of ICD-10, a two- year delay will enable physicians and other stakeholders an appropriate time frame to adjust to such a burdensome, regulatory requirement and help reduce costs weighing on physician practices. It will also help mitigate the disruption to physician practices when advancing to a new diagnostic code set.

Thank you for your attention to this important issue and we are happy to provide any follow up information that may be of assistance to the committee.

Reference

The Impact of Implementing ICD-10, Nachimson Advisors, LLC October 8, 2008
<http://www.nachimsonadvisors.com/documents/icd-10%20impacts%20on%20providers.pdf>

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**Statement for the Record by
Mr. Chris Powell
Chief Executive Officer
Precyse**

**For the
U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health
Hearing on: "Examining ICD-10 Implementation"**

Wednesday, February 11th, 2015

Chairman Pitts, Ranking Member Green, and Members of the Subcommittee:

Thank you for the opportunity to submit testimony for the record of this Subcommittee's hearing, "Examining ICD-10 Implementation." I value this opportunity to deliver to the Subcommittee the message that ICD-10 is a step forward for our health care system and that industry has made a great investment in effort, time, and resources to prepare for the ICD-10 transition and is ready for the current implementation deadline of October 1st, 2015. Further delays to implementation would cause more harm than good for the health care industry, the patients in our system and for health care outcomes.

Who We Are

By way of background, Precyse is a health information management organization that is an industry leader in health performance management and technology. We have enabled nearly 4,000 healthcare facilities and systems nationwide to improve efficiency and deliver tangible clinical and financial outcomes. Our industry-leading expertise and technologies empower health care organizations to most effectively capture, organize, secure, and analyze clinical data so that it becomes more than numbers and statistics; it becomes powerful information that improves financial performance and, most importantly, ensures a healthy organization to promote a health population.

Precyse employs nearly 1,500 colleagues in all 50 states. More than 150 of our colleagues are based in Pennsylvania, our largest state, followed by Florida, Georgia, and Ohio. Across the country, we have colleagues embedded within more than 100 hospitals and provide services and technology for thousands more.

In Pennsylvania, some hospitals that we partner with are Hahnemann in Philadelphia, Sacred Heart in Allentown, Geisinger Health System in Danville and St. Joseph Regional Health Network in Reading. We are also particularly proud of our work with Aria Health, with three leading-edge community hospitals and a strong network of outpatient centers and primary care physicians. We partnered with Aria to help them implement a quality-driven Clinical Documentation Improvement program (CDI). The program paid for itself within the first month of implementation and helped the network save \$800,000 in just eight months.

Additionally, we currently work with the Naples Community Health System (NCHS), a 680 bed system in southwestern Florida. Working with Precyse to implement a Clinical Documentation Improvement (CDI) program and to train its staff and increase its documentation quality and coding competency. NCHS has been able to substantially reduce the number of accounts where a patient has been discharged but the charges have not been processed and the reimbursement bills have not been submitted. Additionally, NCHS' coding accuracy has improved to a 98% success rate.

Precyse has approximately 130 colleagues who reside in Georgia. These colleagues support our company's corporate operations housed in Alpharetta, GA as well as deliver remote, travelling

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and on-site services and support to hospital clients including Meritus Health in Hagerstown, MD, Prince William Hospital in Manassas, VA and St. Mary's Hospital in Waterbury, CT.

Precyse has approximately 20 colleagues who reside in Vermont, including the company's Chief Executive Officer, Chris Powell and the company's Chief Technology and Strategy Officer, Debra Stenner. These colleagues support our company's technology development efforts, specifically building our health information management automation platform that combines clinical documentation improvement, case management, utilization review, coding, abstracting, core measures, and auditing functions into a single integrated platform. Recently, Precyse announced that it has partnered with Vermont HITEC to fill Precyse's current and future medical coding workforce development needs in Vermont. This program is a collaborative effort involving the U.S. Department of Labor, the Vermont Department of Labor, the Vermont Agency of Commerce, Vermont HITEC, and Precyse. Sixteen individuals have been selected for a ten-week education program with Precyse. Upon graduation from the program, participants will fill open medical coder apprentice positions. All positions will receive full wages and benefits.

Additionally, Precyse offers an ICD-10 learning tool known as Precyse University, currently used by 1.8 million learners across the healthcare industry. Precyse University is revolutionizing healthcare education with the most innovative and complete education solution to ease providers' ICD-10 conversion. We provide industry-leading on-demand eLearning and mobile content for all populations impacted by the ICD-10 transition. This includes ICD-10 readiness training for physician groups of all sizes via the Web and in a digestible \$600-\$1,500 per practice investment. Precyse University helps learners prepare for ICD-10, support their Clinical Documentation Improvement initiatives, enhance their coding and reimbursements, and more. Precyse University helps ensure success with a robust, one-of-a-kind learning system that is customized to fit a provider's needs.

The Benefits of ICD-10

Under current law, entities covered by HIPAA must transition from ICD-9 to ICD-10 by October 1st, 2015. The transition to ICD-10 is occurring because ICD-9 produced limited data about patients' medical conditions and hospital inpatient procedures. ICD-9 is more than 30 years old, has outdated medical terms, and has not kept up with modern medical practices.

ICD-10 enables healthcare efficiency and improves patient outcomes. ICD-9 is a reimbursement system that provides minimal tracking data on what procedures, devices, and treatments are effective. ICD-9 has limited ability to track the impact and cost implications of chronic conditions and their treatments. Better medical information allows major refinements to reimbursement systems, including the design and implementation of pay-for-performance programs. ICD-10, on the other hand, provides more precise and comprehensive medical data, which will improve medical performance, create efficiencies, and better contain costs. ICD-10 reduces the need for providers and payers to provide burdensome supporting documentation; it leads to fewer erroneous and rejected reimbursement claims; and it facilitates the development of better tools for detection of questionable billing practices and suspected fraud.

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Medical care has advanced significantly in recent decades. As a result, ICD-9 is an antiquated system that does not reflect advances in technology or care. ICD-10 is a more precise system of medical coding for assessing quality of care and tracking diagnosis for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases. ICD-10 codes were requested by medical specialty societies and clinicians who needed the additional specificity that could not be met by ICD-9.

Physicians will benefit from ICD-10's greater specificity, more accurate reimbursements, and fewer claims denials. ICD-10 enables physicians to capture important details, such as laterality and the severity of patients' conditions. ICD-10 also provides physicians with greater opportunities for appropriate reimbursement. For example, ICD-9 has no way of coding for a Crohn's Disease patient with rectal bleeding, which is a far more serious condition. Being able to capture severity will enable physicians to get appropriately compensated for treating more serious conditions. Another example is laterality: doctors may have claims denied when treating chronic conditions that spread to various areas of the body – claims may be mistakenly denied for the same condition that now appear on the other side of the body. ICD-10 enables physicians to accurately classify laterality, thus minimizing medical payment errors and streamlining payments.

Ultimately, ICD-10 helps protect and improve public health and will improve outcomes for your constituents. ICD-10 helps the public health system detect, rapidly verify, and respond appropriately to epidemic-prone and emerging disease threats – such as Ebola – to minimize their impact on the population's health and economy. The newer codes' specificity more fully captures nationally reportable public health diseases, diseases related to the top ten causes of mortality, and diseases related to terrorism.

ICD-10 will track injuries and treatments, such as traumatic brain injuries (TBI), of importance to population groups such as military veterans and student athletes. ICD-10 enables physicians to code for severity of trauma, track repeat injuries, and to link concussions to other life-altering and debilitating conditions. ICD-9 lacks the means to even code for repeat concussions.

ICD-10 accurately captures the cost of healthcare and readmissions. Today, we have no way of knowing why a patient is not taking medications, yet under-dosing is a leading cause of hospital readmissions. Understanding and addressing the circumstances that lead to under-dosing will reduce costs and waste.

The Health Care Industry is Ready

The United States' health care industry has already spent billions of dollars preparing for the implementation of ICD-10. Hospitals and most doctors are ready for ICD-10 today. ICD-10 should have been implemented more than three years ago, but several delays have already occurred. Meanwhile, the nation's health care industry moved forward, diligently preparing and making investments for ICD-10, with many physicians taking advantage of free preparation resources from the Centers for Medicare & Medicaid Services (CMS).

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Additional delays to ICD-10 implementation would be wasteful and punish the majority of the industry that dutifully prepared and are ready to implement. The U.S. Department of Health and Human Services (HHS) estimates that the cost to delay the implementation could potentially reach \$6.8 billion. Thousands of workers (approximately 60,000 in the coding community) have trained on ICD-10 and stand ready to apply their skills. Most colleges and training centers have already shifted their focus to teaching ICD-10 in expectation of this transition. As a result, there is a pool of newly trained graduates who are not able to enter the workforce until the transition to ICD-10 is made.

As I recently wrote, it is difficult to argue that you can build a modern structure of significance on a crumbling foundation. ICD-9 is that crumbling foundation. Perhaps more important than the monetary assessment of additional delays is the lost opportunity that will result when an antiquated, 20th century coding scheme hobbles America's ability to build a 21st century health care system.

I appreciate the opportunity to submit remarks to this Subcommittee. Precyse looks forward to the implementation of ICD-10 this October, and we offer to serve as a resource for the members and staff of this Subcommittee.

Very Respectfully,



Chris Powell
Chief Executive Officer
Precyse

Survey of ICD-10 Implementation Costs in Small Physician Offices

Karen Blanchette, MBA, Richard Averill, MS, and Susan Bowman, MJ, RHIA, CCS

The Professional Association of Health Care Office Management (PAHCOM) is the association for managers of physician practices. Because there has been much speculation concerning the cost of implementing ICD-10 for small physician practices, PAHCOM conducted a survey of its membership to assess the ICD-10-related costs actually being incurred by small physician practices with a focus on practices with six or fewer direct care providers. Of the available studies on the ICD-10 transition costs for small physician practices, this study is only the second that is based on a direct survey of small physician practices.

Survey Questions

Survey respondents were asked to specify the number of providers in the practice where a provider was defined as a direct caregiver, such as physicians, physician assistants, and nurse practitioners. Survey respondents were asked to specify the total expenditures in the practice for all ICD-10-related activities, including costs already incurred and costs remaining to be expended. The instructions associated with the question on expenditures specifically noted that the costs of obtaining ICD-10 manuals and documentation, ICD-10 training costs, the cost of superbill conversion to ICD-10 and software system upgrades and testing should all be included as ICD-10-related expenditures.

Karen Blanchette is association director for the Professional Association of Health Care Office Management, Richard Averill is director of public policy for 3M Health Information Systems, Inc., Susan Bowman is senior director, coding policy and compliance for the American Health Information Management Association.

Survey Results

There were 276 survey responses from practices with six or fewer providers. The survey results for these practices are contained in the following table:

Number of Providers	Number of Responses	Practice Average Expenditures	Per Provider Average Expenditures
1	83	\$ 4,372	\$ 4,372
2	69	\$ 6,620	\$ 3,310
3	39	\$ 9,641	\$ 3,214
4	37	\$13,541	\$ 3,385
5	30	\$11,960	\$ 2,392
6	18	\$11,028	\$ 1,838
	276	\$8,167	\$3,430

Generally, as expected, the expenditures associated with ICD-10 increase as the size of the practice increases, but the per provider expenditures decrease as the size of the practice increases. The per provider ICD-10 average expenditures ranged from \$4,372 for a practice with a single provider to \$1,838 for a practice with six providers. Overall, for the 276 practices with six or fewer providers, the average ICD-10-related expenditures for the entire practice were \$8,167 with average expenditures per provider of \$3,430. There were insufficient responses from larger practices with seven or more providers so these practices were not included in the analysis.

Survey respondents were also asked to specify the total amount of ICD-10-related

time expended by all personnel in the practice, including physicians, non-physician providers, office management, and other support staff. On average, the combined amount of ICD-10-related hours expended across all personnel types in practices with six or fewer providers was 45.5 hours per provider in the practice.

Comparison to Previous Estimates

The ICD-10 expenditures reported in this survey are somewhat higher than reported in two recent studies. One study estimated the ICD-10 conversion costs for an office with three providers to be \$1,960-\$5,900.¹ In a second study, the American Academy of Professional Coders (AAPC) conducted a survey of the ICD-10 implementation costs in small physician practices (defined by AAPC as a practice with under 10 providers).² The AAPC survey found that ICD-10 implementation costs averaged \$750 per provider in a small physician practice. The lower per provider estimate in the AAPC survey may possibly be due to limitations on the types of implementation costs included in the AAPC data and/or the additional costs that have been incurred as a result of the delay in implementation of ICD-10.

The ICD-10 expenditures reported in this survey and the two other recent studies are dramatically lower than the \$22,560-\$105,506 estimate for a small practice in an earlier study commissioned by the American Medical Association (AMA).³ The lower costs reported in this survey may be in part due to vendor response to the implementation of ICD-10. ICD-10 educational materials are now readily available for a nominal cost. Practice specialty-specific superbills can be downloaded at no cost from the internet. Many software system vendors are providing ICD-10 system updates at no additional cost. The adoption of electronic health records by

physician practices has further facilitated the transition to ICD-10.

Conclusions

This survey found that the average ICD-10-related expenditures for a physician practice with six or fewer providers is \$8,167 with average expenditures per provider of \$3,430. These results represent the most comprehensive and current data on the ICD-10 implementation costs actually being incurred in small physician practices. There are now three studies documenting that ICD-10 implementation costs in a small physician practices are dramatically lower than originally reported in the widely publicized AMA-funded study. Based on this survey and the two other recent studies, the financial barriers to ICD-10 are significantly less than originally projected.

References

1. Kravis, Thomas C. et al. "Cost of Converting Small Physician Offices to ICD-10 Much Lower than Previously Reported." *Journal of AHIMA* website. November 12, 2014. <http://journal.ahima.org/?p=10372>.
2. Buckholtz, Rhonda. "Exclusive: ICD-10 Implementation – Where Do We Really Stand?" June 9, 2014. <http://icd10monitor.com/enews/item/1220-exclusive-icd-10-implementation-where-do-we-really-stand>.
3. Nachimson Advisors. "The Cost of Implementing ICD-10 for Physician Practices: Updating the 2008 Nachimson Advisors Study: A Report to the American Medical Association." February 12, 2014. <https://download.ama-assn.org/resources/doc/washington/x-pub/icd-10-costs-for-physician-practices-study.pdf>.

FIRST PUBLISHED ONLINE AT <http://journal.ahima.org>

KEY-WHITMAN EYE CENTER
Dallas, TX

RE: ICD-10 Issues

To: Chairman Pete Sessions
House Committee on Rules
2233 Rayburn House Office Building
Washington, D.C. 20515-4332

Recently, an inquiry by you was made regarding our position on the implementation of ICD-10. Based upon our vast experience in medicine, coding, reimbursement, clinical productivity and integrated information systems, we offer the following key points.

- 1) First and foremost, tying CMS reimbursement with detailed clinical coding information with the required granularity of ICD-10 is fraught with a host of impractical implementation issues. While better clinical coding systems are desirable for clinicians and statisticians monitoring public health trends, ICD-11 planned for 2017 may do a much better job, and ICD-10 is not a transitional system. Reimbursement detail, for the most part, is irrelevant to clinical coding when correlating it with the full scope of ICD-10 digits being mandated in the USA. Accuracy is predicted to be very poor since the emphasis will be on reimbursement rather than clinical value. Practically all the other nations of the world do not tie ICD-10 with reimbursement, and other nations in the use of ICD-10 vary considerably amongst advanced nations. It has been stated that no other nation will use ICD-10 like the United States intends to use it. So, adopting the ICD-10 system because many other nations use it really does not hold much value or analytical comparability.
- 2) Given our recent industry history of implementing the E.H.R. or E.M.R. systems for medical practices, many of our I.T. systems are simply incapable and cratering under the pressure of meeting Meaningful Use 2 goals, besides the PQRS reporting requirements, placing the complexity of the ICD-10 program on top of the MU-2 stages & PQRS mandates is going to overwhelm most practices given their level of employed personnel and I.T. support services. The staggering implementation of multiple complex systems simultaneously with lower level educated personnel will simply not work well in reaching the goals. Failure, similar to the start-

up of "healthcare.gov," will be repeated. Delaying the implementation will be helpful when the other informational programs are more stable.

- 3) The relative impact on productivity and workflow will be costly for the medical practice, adding personnel to handle the detailed processes of ICD-10 for reimbursement, as well as prolonging the processing of patients, will slow the current system by 5-10%, in my opinion. More effort will be directed to documenting the ICD-10 process than attending to the clinical needs of the patient.
- 4) The cost of training and preparation will be extremely costly for most practices, amounting to many thousands of dollars per doctor for each practice on top of the declining reimbursement trends and escalation of more elaborate cost to support the new electronic health systems. I predict that the cost squeeze will bankrupt smaller practices unprepared to handle the cash flow needs of the ICD-10 implementation in 2015. Delaying it to 2018 would be a better solution, as we will likely implement ICD-11 at that time.
- 5) Many practice management systems that do the billing for medical practices will likely not be fully capable, despite the lead time provided with the extension. As I sit on the Board of an I.T. company that hosts a variety of billing systems, we are fully aware of their inadequacies since we test their performance levels. The testing process is not adequate with so much at stake financially for medical practices.
- 6) Expectations of the payers to be prepared for the full implementation of ICD-10 will not occur. They have had trouble with the 5010 implementation. They have a lot of trouble with the Quality/Cost database ratings of physicians. As we have continually experienced, system upgrades by United Health Care, Cigna, Aetna, Blue Cross, Wellpoint, etc. , they rarely are prepared for such major changes on a timely basis. Major overhauls of their I.T. claim processing systems have historically been poor at best. Thus, reimbursement claims will be denied, unpaid, improperly paid, and re-worked at a staggering level. Payers have little incentives to be fully prepared on time, and much to gain by holding back payments. Medical practices will predictably need additional months of working capital funds just to get through the implementation, and our tax system does not encourage a build-up of working capital by physicians to survive the ICD-10 implementation.

In conclusion, we see no need to upgrade to the ICD-10 by October 1, 2015 which will be extremely costly to medical practices without any value, and we would see our national system better served adopting ICD-11 by 2018 with more testing and stabilization of our current EMR / EHR installations along with PQRS compliance.

Respectfully,

Daniel D. Chambers
Executive Director, Key-Whitman Eye Center



February 4, 2015

The Honorable Tony Cardenas
1510 Longworth House Office Building
Washington, D.C. 20515

Dear Representative Cardenas,

On behalf of more than 400 member hospitals and health systems, the California Hospital Association (CHA) strongly supports the announced October 1, 2015 ICD-10 compliance date. After multiple delays, the current compliance date provides ample time for health care entities to prepare for the transition, educate clinical and administrative staff, upgrade all technology and conduct the necessary testing to ensure successful implementation.

Importantly, CHA opposes any steps to delay this implementation date. California hospitals made significant investments in preparing for the October 2014 implementation, and the delay added millions of dollars in extra costs. Many hospitals had to reconfigure systems and processes that were prepared to use ICD-10 back to ICD-9. Coders who were newly trained to use ICD-10 had to be retrained back to use ICD-9 and training of existing coders had to be repeated as a result of the delay. Any further delays would only add additional costs to the vast majority of hospitals that have already spent tremendous resources preparing for the 2015 implementation date.

ICD-10 implementation delays have been disruptive and costly to California hospitals. In addition, the delays have stalled health care delivery innovation and disrupted payment reform. Any further delays would only hinder the momentum toward implementation, and the resources dedicated to the transition would likely be diverted elsewhere, making the process more difficult.

California hospitals are committed to and believe strongly in the importance of moving to ICD-10 on October 1, 2015. We urge Congress to avoid any further delays of this needed coding update.

If you have any questions, please contact Anne O'Rourke, senior vice president federal relations, at aurourke@calhospital.org, or (202) 488-4494.

Sincerely,

C. Duane Dauner
President and CEO

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
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Majority (202) 724-2872
Minority (202) 724-3844
February 25, 2015

Dr. Edward M. Burke
Bayer Medical Group
735 West Main
Fredericktown, MO 63645

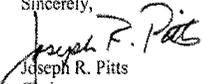
Dear Dr. Burke:

Thank you for appearing before the Subcommittee on Health on Wednesday, February 11, 2015, to testify at the hearing entitled "Examining ICD-10 Implementation."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Tuesday, March 10, 2015. Your responses should be mailed to Adrianna Simonelli, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Adrianna.Simonelli@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment



BEYER MEDICAL GROUP
735 West Main Street
Fredericktown, MO 63645
Ph: (573) 783-8875 Fax: (573) 783-8890
Phillip Beyer, DO
Edward Burke, MD
Starla Dulworth, APRN-BC
Frank Klima, APRN-BC
Jamee Rehkop, CPNP-PC
Debbie Reichert, MSW, LCSW

March 6, 2015

Response to Additional Questions for the Record

Asked by The Honorable Ben Ray Lujan

A. How do you think that rural providers will be impacted by the transition to ICD-10?

It is our belief that the impact to rural providers will be no different than impact felt by providers everywhere. There is no doubt it will be a huge change. There could be added time spent in seeing a patient and possibly in documentation. But it can be very simple as we have found in our clinic. We cannot predict the challenges of every office. Nor do we confess to knowing the difficulties each office will face. But the fear mongering that has been out for there for the past few years proved not to be so in our office. We had no economic impact. Which we believe is the real fear. We were able to see the same amount of patients as before we implemented the new code set. There was no disruption in the flow of the office at all. Patients were not affected in any way. We spent no additional money to prepare. A comment was made from one of the members that that could not be true. But it is. Yes, we pay support fees for our electronic medical records. We have since implementation. But there were no additional costs for the move to ICD-10. We had no special training or any training at all for that matter. There are many resources available to assist in this change. In fact, have been available for quite some time.

B. I was glad to hear that you have been preparing for several years for the adaption of ICD-10. What steps can other rural providers take to prepare for the transition?

Actually, we have not spent several years preparing. We were asked to join a pilot program our software company was offering. We have been effectively using ICD-10 since October 2013. The effort for us was led by our software. Providers need to be contacting their vendors and asking what they have done to prepare for ICD-10. We recommend getting involved as early as possible. Most EHR's are preparing. If the provider is not using an EHR then they could contact CMS, their local associations and/or one of the many assistance programs out there. There is help. A lot of it is free or for very little cost. Also a good way of preparing for this and other significant changes though is to have a professional healthcare manager running the office and business end of the practice. There is no question the burden providers have right now is unprecedented. But ICD-10 does not need to be one of those burdens. We believe it will actually make a lot of systems in healthcare easier. Providers have enough to do taking care of patients. That is where their focus should be. Not on ordering supplies, doing payroll and worrying about all the new and complicated programs being mandated. They should have qualified professionals within their own organization to rely on for these answers. That is the best way to prepare. Hire good quality certified employees who not only understand what is coming but have solutions as well.

C. You mentioned that you took part in a pilot program. Can you speak to the parts of that program that made your transition to ICD-10 a success? Do you think it would be beneficial for other providers to have access to the same program/training?

Yes, absolutely. And thank you for this question. So, this is how it worked for us: the ICD-10 code set was uploaded to our system. When choosing a diagnosis for a patient during documentation instead of having ICD-9's to choose from we had ICD-10's. A list of appropriate codes based on the documentation pops up and we choose the code that best applies to describe the patient's symptoms. Before the claim goes out to billing the software automatically switches the '10' code to an appropriate '9' code so that it is recognized and payable by insurance companies. That's it... it is truly that easy. Even though there are tens of thousands of codes, we only choose that we need. We in no way come close to using them all or needing to know them all. If other software companies have such programs absolutely other providers would benefit from having access. The point of it being a pilot program is to be able to work out any kinks, seeing what works and what doesn't work. It allows both the provider and the software developers to learn from each other. It gives the provider basically free training as they learn the new parts of the system. We felt like it would give a chance to learn about ICD-10 and be comfortable with it before it really counted. We the deadline was extended again we decided to continue using. It just had no effect on how we did business. Everything stayed the same. It just made sense to keep moving forward. It was a clearer, more descriptive picture of what was actually going on with the patient. And we liked that. When referring to a patient issue at a later date the detail in the ICD-10 diagnosis is helpful.

D. In your testimony you referenced several challenges that providers face. Do you have any suggestions for how this committee can ensure that rural providers continue to serve our communities?

Yes, just please continue to recognize that providing services in rural communities is different than in more urban areas. Things may move a little slower here but our needs are basically the same. Access to information is one of our biggest challenges. Funding for Rural Health Clinics is critical for offices to stay operational. Just because we are rural though doesn't mean we do not provide quality care and aren't capable of having current information. It may mean we have to

work a little harder, but we believe are patients are worth it. Rural does not have to equal old fashioned. We want to be leaders too.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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Minority (202) 225-3641

February 25, 2015

Mr. Rich F. Averill
Director of Public Policy
3M Health Information Systems
100 Barnes Road
Wallingford, CT 06492

Dear Mr. Averill:

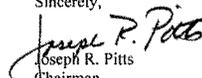
Thank you for appearing before the Subcommittee on Health on Wednesday, February 11, 2015, to testify at the hearing entitled "Examining ICD-10 Implementation."

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment



3M Health Information Systems, Inc.
100 Barnes Road
Wallingford, CT 06492

March 11, 2015

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Pitts,

Thank you again for the opportunity to testify at the February 11, 2015 hearing entitled "Examining ICD-10 Implementation." We greatly appreciate the Committee's attention to this important coding upgrade for our health care system.

Thank you also for sharing questions for me to respond to from Committee Members as follow up. I am pleased to provide these responses to the Committee.

Should you need any additional information, please contact Megan Ivory Carr at 202.414.3042 or mmivory@mmm.com.

Sincerely,



Richard F. Averill

Cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Questions from The Honorable Frank Pallone, Jr.

1. Can you help us understand the effect each time implementation is delayed? Who does the delay affect?

The impact of a delay cascades throughout the entire healthcare industry. Because of the long lead times involved in transitioning major payer, vendor and provider software systems to ICD-10, the vast major conversion work has already been completed and is the final acceptance testing phases. At the same time the existing ICD-9 version of these systems have to be kept fully operational. Maintaining parallel systems in ICD-9 and ICD-10 is very labor intensive and costly. In addition, the October 2015 update not only implements ICD-10 but will also contains many other scheduled and required regulatory and system updates. These October regulatory and system updates have all been developed and tested based on ICD-10. Since ICD-9 will not be used after October 1, 2015, an ICD-9 version containing the October 2015 regulatory and system updates are not being developed. If ICD-10 is delayed, there would have to be an unplanned and unreasonably short development and testing effort to updated the ICD-9 version for the October 2015 regulatory and system updates. The unplanned update to the ICD-9 version would be a significant effort plus it would mean another year of incurring the cost of maintaining parallel ICD-9 and ICD-10 systems.

In addition to the direct costs of the delay, significant ongoing costs are being incurred by the failure to replace the ICD-9 code set. Continued use of the out-of-date and imprecise ICD-9-CM code set results in costs associated with:

- Inaccurate decisions or conclusions based on faulty or imprecise data
- Administrative inefficiencies due to reliance on manual processes
- Coding errors related to code ambiguity and outdated terminology
- Worsening imprecision in the ICD-9-CM code set due to the inability of the structure to adequately accommodate requested modifications
- Ongoing maintenance of both the ICD-9-CM and ICD-10 code sets.

Each delay adds substantially to the cost of ICD-10 conversion - the last one year delay is estimated to have cost the health care sector \$6.5 billion dollars. CMS has estimated that \$20 billion will be spent getting ready for ICD-10. Because of the long lead times involved in transitioning major software systems, the vast major of those costs have already been incurred and grow with each additional delay.

During the E&C hearing, a dual coding system approach was proposed in which providers would be allowed to submit claims coded in either ICD-10 or ICD-9 during a transition period. While a dual coding system may sound straightforward, it would require extremely complex and costly changes to major payment, clearinghouse and provider systems that are not practical or feasible. Even more troubling, the communication of health information between providers would be compromised,

adversely impacting the quality of patient care and increasing the potential for patient harm.

The entire data infrastructure of the healthcare industry has been designed to take advantage of the standardization on a single coding standard for electronic health care transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This standardization has dramatically improved the overall efficiency and effectiveness of the healthcare system. Dual coding would undo this standardization requiring payment, clearinghouse and provider systems to be able to switch back and forth on a claim-by-claim basis between ICD-9 and ICD-10. This would necessitate a complete redesign, restructuring, reprogramming and testing of these systems.

Reengineering on such a massive scale would inevitably lead to payment errors and discrepancies and communication breakdowns due to inaccurate processing and linking of claims across providers. This could leave patients bewildered and faced with either paying bills themselves that should not be their responsibility or trying to sort out the confusion with their providers and payers. Dual coding would actually increase not decrease, the likelihood of payment errors and communication disruptions. Organizations with networks of providers, such as accountable care organizations, would be unable to efficiently communicate across healthcare providers or effectively analyze costs, outcomes of care, and patient safety.

A dual coding system is fraught with difficulties that have the potential to undermine the data infrastructure of the healthcare industry. It will confuse claims processing and negatively impact the handling of important patient clinical information and possibly patient care.

2. What types of training and resources go into preparing for ICD-10 implementation? What is the cost of delaying?

Many professional organizations as well as commercial vendors offer extensive resources for education and implementation preparation. Training is available in a variety of formats – face-to-face, online, videos or podcasts, etc. CMS also offers extensive training and other resources – YouTube videos, “Road to 10” initiative aimed at providing training to small physician practices, timelines, checklists, fact sheets, etc.

Organizations such as the American Health Information Management Association (AHIMA) and the American Academy of Professional Coders (AAPC) offer comprehensive education for coding staff. AHIMA also has trained thousands of ICD-10 trainers that train coders in all provider settings in their local communities. AHIMA has chapters in every state that are reaching out to physicians and physician practices in their states to provide ICD-10 education and implementation guidance. Many AHIMA members are providing ICD-10 education at their institutions for their medical staff.

AHIMA, AAPC, the AMA, medical specialty societies, and many other organizations provide both face-to-face and on-line education for physicians to help them assess and improve clinical documentation.

The ICD-10 code sets themselves are available electronically free of charge from CMS and the National Center for Health Statistics. Coding software is also available at a variety of price points. Low-cost mobile apps and other electronic tools are available to facilitate the coding process as well as provide documentation tips for ICD-10. Technology is also available to provide “real time” documentation improvement tools to facilitate documentation capture at the point of care, including documentation “prompts” in electronic health record systems.

Regarding the cost of delay, the total cost is noted in the answer to question #1 above. Any ICD-10 delay is disruptive and costly for healthcare delivery innovation, payment reform, public health, and healthcare spending. Since the final rule adopting the ICD-10 code sets was published in 2009, the healthcare industry has made significant investments in the ICD-10 transition. Considerable time and resources have been invested in financing, training, and implementing the necessary changes to workflow and clinical documentation. Implementation costs continue to increase considerably every year of a delay. These costs include:

- ICD-9-CM versions of systems will have to be updated to remain current and usable.
- Each delay requires ICD-10 conversion work already performed to be updated, retested, and reintegrated – greatly increasing the cost of conversion.
- Maintaining coders’ ICD-10 coding skills through either additional education or ongoing ICD-10 coding practice.
- Adjusting academic curricula according to changes in the compliance date so that students are educated in the coding system in use at the time of their graduation.
- Re-educating graduates of students in health information management associate, baccalaureate, and coding certification educational programs that received ICD-10 education only but are now faced with a healthcare system still using ICD-9.
- Decreased employment opportunities for graduates of health information management and coding programs who were educated only in ICD-10 but ICD-9 is still in use at the time of their graduation due to a delay in the ICD-10 transition.
- Costs associated with the inability to effectively use healthcare data to improve quality of care, patient safety, and patient outcomes because the quality of healthcare data is progressively deteriorating as long as the US continues to rely on the outdated and imprecise code set.

Additionally, as has been observed with previous delays in ICD-10 implementation, those entities that were behind in their implementation preparation continued to lag behind in spite of the delay, as they did not use the additional time to their advantage. And entities that were on track for the established compliance date prior to announcement of a delay began to lag behind after the delay, due to loss of organizational momentum and focus, diversion of funding and personnel to other, more pressing projects, and growing skepticism as to the “firmness” of a compliance date. The fact that there have been two delays since the final rule was published, and each of these delays has cost the healthcare industry billions of dollars, has increased industry caution in expending resources on ICD-10 preparation until closer to the compliance date, when the risk of another delay seems small. Thus, delays have not proven beneficial to anyone in terms of achieving greater industry readiness.

Resources listed below are a samples of some of the key ICD-10 resources for physicians available:

AMA: ICD-10 Resources

<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act/transaction-code-set-standards/icd10-code-set.page>

- Medicare Testing and Payment
- ICD-10 FAQs
- ICD-10 Implementation Planning (these are AMA member-only resources)
- Educational Resources (some of these are member-only resources)
 - [Free Educational Resources](#) - White papers and practice tools on the following:
 - Revised CMS-1500 Health Insurance Claim Form: Understanding the Changes in Version 02/12
 - ICD-10 Action Plan: Your 12-Step Transition Plan for ICD-10
 - “Achieving the Benefits Promised by Administrative Simplification, ICD-10, and EHRs”
 - “What You Need to Know for the Upcoming Transition to ICD-10-CM”
- [AMA Training and Events](#)

CMS: Provider Resources

CMS many free resources to assist physician practices and other providers with the ICD-10-CM transition, including fact sheets, implementation guides, checklists, timelines, webinars, and provider teleconferences.

<http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html>

- [Road to 10: The Small Physician Practice's Route to ICD-10](#)
 - ICD-10 Overview

- Physician Perspectives (hear from physicians on the value of ICD-10)
- Webcasts (Specialty Documentation and Road to 10 series)
- Specialty References
 - Specialties: Family Practice, Pediatrics, OB/GYN, Cardiology, Orthopedics, Internal Medicine, Other Specialty
 - References: common codes, documentation needs, clinical scenarios, resources
- Build your Action Plan (customized action plan for physician offices)
- Fact Sheets
 - [ICD-10-CM/PCS Myths and Facts](#)
 - [ICD-10 Basics for Medical Practices](#)
 - [ICD-10 Basics for Small and Rural Practices](#)
- [Talking to Your Vendors About ICD-10: Tips for Medical Practices](#)
- [Online ICD-10 Implementation Guide](#)
- YouTube Videos
 - [ICD-10 Coding Basics](#)
 - [Coding for ICD-10-CM: More of the Basics](#)
 - [ICD-10 and Clinical Documentation](#)

AHIMA: ICD-10 for Physicians & Clinicians

<http://www.ahima.org/topics/icd10/physicians>

- Why ICD-10 Matters
- Documentation Improvement
- Implementing ICD-10
- Training
 - [Clinical Documentation Training for ICD-10 by Specialty](#)
- Free resources for physicians include:
 - [Top 10 ICD-10-CM/PCS Questions](#)
 - [Electronic Documentation Templates Support ICD-10-CM/PCS Implementation](#)
 - [ICD-10-CM/PCS Documentation Tips](#)
 - [Setting the Facts Straight About ICD-10: What Physicians Need to Know About the Transition](#)
 - [Cost of Converting Small Physician Practices to ICD-10 Much Lower than Reported](#)

Other Resources

- The ICD-10-CM coding system is available free of charge from [CMS](#) and the [National Center for Health Statistics \(NCHS\)](#). The *ICD-10-CM Official Guidelines for Coding and Reporting* are available free of charge from [NCHS](#).
- [American Academy of Professional Coders](#)

- [ICD-10 training for coders](#)
- [ICD-10 documentation training for physicians](#)
- [Professional Association of Health Care Office Management \(PAHCOM\)](#)
 - [PAHCOM/CMS Partnership Webinar Recordings](#)
- The "[Rural ICD-10](#)" [web site](#) offers information and free resources to assist rural health providers in transitioning to ICD-10.

Medical Specialty Societies and State Medical Societies

Many medical specialty societies and state medical societies offer ICD-10 education and implementation resources, such as:

- [AAFP: FAQs on ICD-10](#)
- [Wisconsin Medical Society: ICD-10 Education & Resources](#)
- [American College of Physicians: ICD-10 Resources](#)
 - [Commonly-Used ICD-10-CM Codes](#)
- [American College of Surgeons: ICD-10 Information and Training](#)
- [American Academy of Orthopedic Surgeons: Practice Management Center \(ICD-10 Resources\)](#)
- [American Congress of Obstetricians and Gynecologists: ICD-10](#)
 - [Training](#)
 - [ICD-9 to ICD-10 Obstetrics Crosswalk](#)
- [American Academy of Pediatrics: ICD-10-CM - Coming October 2015](#)
 - [ICD-10-CM Webinars](#)

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK FALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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WASHINGTON, DC 20515-6115
Majority (702) 225-2927
Minority (202) 225-3641

February 25, 2015

Ms. Kristi A. Matus
Chief Financial and Administrative Officer
Athena Health
311 Arsenal Street
Watertown, MA 02472

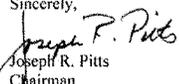
Dear Ms. Matus:

Thank you for appearing before the Subcommittee on Health on Wednesday, February 11, 2015, to testify at the hearing entitled "Examining ICD-10 Implementation."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Tuesday, March 10, 2015. Your responses should be mailed to Adrianna Simonelli, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to Adrianna.Simonelli@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

March 4, 2015



The Honorable Joseph Pitts
Chairman, Subcommittee on Health

311 Arsenal Street
Watertown, MA 02472

The Honorable Frank Pallone, Jr.
Ranking Member

House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pitts and Ranking Member Pallone,

I was honored to testify last month on behalf of athenahealth, Inc. at the Subcommittee on Health's hearing, "Examining ICD-10 Implementation." I thought the questions posed by the Subcommittee were insightful, and the discussion illuminating. I appreciate the further opportunity to respond to Mister Pallone's excellent follow-up questions.

As noted in my submitted testimony, athenahealth provides electronic health record ("EHR"), practice management, care coordination, patient communication, data analytics, and related services to physician practices, working with a network of more than 60,000 healthcare professionals who serve over 60 million patients in all 50 states. All of our providers access our services on the same instance of continuously-updated, cloud-based software. Our clients' successes, exemplified by a Meaningful Use attestation rate more than double the national average, underscore the very real potential of health IT to improve care delivery and patient outcomes while increasing efficiency and reducing systemic costs.

Those successes, and the services platform that enables them, are directly relevant to the responses below.

The Honorable Frank Pallone, Jr.:

1. Ms. Matus, you mentioned in your testimony that all 60,000 of athenahealth's providers were ready for last year's deadline and will be ready for the October 1 deadline.
 - a. Can you explain why your providers are universally ready as compared to other providers—what can they do to get ready for the transition?

Our providers were and are universally ready for ICD-10 because we have financially guaranteed their readiness and completed the work necessary to make them ready on their behalf. A brief explanation of the fundamental nature of a cloud-based service will illuminate how we have made our clients ready and why we are able to stand behind that readiness with a financial guarantee.

As you may know, most of health information technology in this country is still dominated by the static enterprise software model. What this means in the simplest terms is that the information technology systems in prevalent use in our healthcare system are pieces of software installed and customized individually at the point of use. Post-installation they are not connected in any ongoing sense with each other or with the vendor responsible for the software. Because the systems are installed and customized locally, upgrades—such as an upgrade necessary to implement ICD-10—must be made locally, on an individual basis.

The implications of this situation extend much further than ICD-10, but ICD-10 serves as a useful illustration of its inherent deficiencies in our increasingly connected information economy. Imagine if every time an iPhone user wished to update an app on her phone, she was required to arrange for a custom, in-person upgrade for her individual handset. That is essentially the paradigm faced by most consumers of health IT today. It is no wonder, then, that many vendors repeatedly inform their clients that they will be unable to implement an upgrade (and the individualized training that is often necessary in this disconnected paradigm) in time to meet the next deadline...whenever that next deadline may be. The fact that the government continues to reward—or at least excuse—that lack of readiness by repeatedly postponing the supposedly-firm ICD-10 implementation deadline only exacerbates the situation, providing comfort to vendors of anachronistic technology platforms that they may never ultimately have to answer to their clients for their failure to adequately prepare for a relatively rudimentary code set upgrade.

Because athenahealth's services are provided to our clients via a cloud platform, we are literally *connected to our clients at all times*. Our software is updated continuously, often on a nightly basis. Each upgrade is provided to each of our clients simultaneously, ordinarily with no affirmative action necessary on the clients' part. The ICD-10 upgrade will be more significant than our regular upgrades, but the same basic paradigm will attach: we have done the coding work necessary to implement the ICD-10 switch. When the deadline is reached, every one of our clients will be upgraded simultaneously, via the cloud, in functionally the same way that millions of Americans upgrade the apps on their smartphones.

Of course that is just the practical, mechanical component to our clients' ICD-10 preparedness. We have also prepared them emotionally, taking away the anxiety associated with a pending major change by financially guaranteeing a successful switch. This guarantee has two main components: (1) In the unlikely event that a client is unable to switch at the deadline, that client will not be charged for our services until the switch is successfully achieved; and (2) any client who experiences a significant delay in claims processing due to a fault in our implementation of the transition will qualify for a cash advance from athenahealth to ensure continued cash flow.

To be clear: we have budgeted to make good on that guarantee, but we do not expect it to apply to any of our clients because we are confident in the preparation we have done and the power of our cloud platform to deliver its benefits to our clients with minimal disruption.

During the recent hearing you heard from a witness, Dr. Burke, whose practice has already made the transition as part of a pilot program, with no additional incremental cost and no disruption to his practice. We fully expect our clients to experience the same seamless transition. Dr. Burke's experience also illustrates by example that athenahealth is not the only

vendor able to prepare its clients for the ICD-10 transition. Indeed, in a September 2013 survey by the Workgroup for Electronic Data Interchange (WEDI) two thirds of 87 responding vendors indicated that they have ICD-10 ready products available, roughly twice as many as in 2013.

In light of available health IT systems that are capable of meeting the pending ICD-10 deadline, the best thing that the nation's care providers can do to prepare is to exercise their market strength by demanding that their vendors meet the deadline. The government can add heft and credibility to that demand by making it unambiguously clear that this time the deadline is real and will be enforced. The only other responsible alternative, as I explained in my hearing testimony, is to abandon the transition entirely. Another delay will serve no one beyond those vendors that have relied on repeated delays to shield them from the consequences of their technological failures.

The Honorable Frank Pallone, Jr:

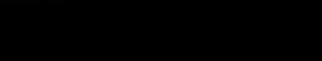
b. Can you talk a little bit more about the effect that last year's unexpected delay had on athenahealth and on your providers?

The fact that athenahealth's clients are ready for the ICD-10 transition should not be read to in any way minimize the significance of the change. Like any significant change, preparation requires significant expenditure of resources—both human and financial. To-date athenahealth has invested more than 200,000 person hours into all aspects of our preparation for the ICD-10 transition, at a cost of many millions of dollars. The lost opportunity costs of such a significant expenditure of resources that would otherwise have been dedicated to other productive activities on behalf of our clients, of course, cannot be quantified.

Likewise, the costs to our clients of repeated cycles of preparation and delay cannot be estimated with any precision, but they are undoubtedly significant. A certain degree of anxiety and uncertainty will always accompany the prospect of significant change. The fact that athenahealth guarantees ICD-10 compliance alleviates our clients' anxiety, but nothing we do can eliminate it entirely. Only you can do that, by resolving once and for all to go forward with the ICD-10 transition as scheduled, or by deciding once and for all to scrap the program and move on with the many other significant reforms that our healthcare system urgently needs.

Thank you once more for the opportunity to participate in this important discussion.

Sincerely,



Kristi A. Matus
Chief Financial and Administrative Officer
athenahealth, Inc.

cc. The Honorable Fred Upton, Chairman, House Energy and Commerce Committee
The Honorable Gene Greene, Ranking Member, Subcommittee on Health

FRED UPTON, MICHIGAN
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February 25, 2015

Ms. Carmella Bocchino
Executive Vice President of Clinical Affairs and Strategic Planning
America's Health Insurance Plans
601 Pennsylvania Avenue, N.W.
South Building, Suite 500
Washington, D.C. 20004

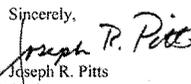
Dear Ms. Bocchino:

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Question from Rep. Pallone to Carmella Bocchino

Can you elaborate on how insurers are held back by ICD-9 codes currently in implementing delivery system reforms and how specifically the ICD-10 code data will help in those efforts.

Carmella Bocchino's Response

- The U.S. healthcare system is moving from fee-for-service, in which payment is based on the number of patients seen by a provider or the specific treatments provided, to models that base payment on outcomes and improvements in health quality. The goal of these payment reforms is to recognize and reward efforts to improve patient health and promote a healthier population. The transition from the current International Classification of Diseases, 9th Revision (ICD-9) to the 10th Revision (ICD-10) for diagnosis and procedure coding is essential to supporting these efforts.
- ICD-10 codes provide more specific and detailed information about a diagnosis or procedure allowing for better measurement of what was done, why the treatment was needed, and the outcome for the patient. For example, ICD-10 codes provide more detail on surgical procedures used to repair the heart and pericardium, leading to a better understanding of which procedures are most clinically effective depending on the underlying diagnosis.
- ICD-10 codes make it easier to obtain information without having to investigate the underlying medical record because the codes capture more detail. It is significantly easier to quantify the relationship between specific medical procedures (e.g., surgeries on the right or left side of the body) and outcomes (e.g., post-surgery infection sites) from a review of ICD-10 codes, than having to individually go through the unstructured surgeon's notes and medical records for each patient.
- A substantial number of ICD-10 codes combine diagnosis and symptoms (as opposed to the ICD-9 coding which may require several different codes to describe a patient's condition). This combination reduces the potential errors or confusion resulting from a provider having to use multiple codes to describe a single event. For example, a single ICD-10 code, E10331: type I diabetes mellitus with unspecified diabetic retinopathy and macular edema, requires three ICD-9 codes to convey the same diagnosis.
- ICD-10 codes provide additional sensitivity in describing diagnosis and procedures allowing providers to be better rewarded for more complicated and difficult interventions with positive outcomes. ICD-9 codes, which tend to treat all similar diagnosis and procedures the same, do not always recognize the different levels of care that may be required within the same treatment, based on the patient's condition.
- ICD-10 codes recognize new disease conditions, treatments, and medical devices. Medical knowledge and treatments are growing and the ICD-9 code set is extremely limited in its ability to adopt new codes. Additionally, ICD-10 codes can expand to

provide greater specificity as we learn more about an existing medical condition or diagnosis.

- ICD-10 codes enhance our ability to identify patients that would benefit from disease management and care coordination programs. Because of their greater specificity and flexibility, the new code system allows providers and payers to better monitor patients who need more intensive follow-up services and determine when disease management and care coordination programs have been effective.

Carmella Bocchino: Additional Discussion of Dual Tracking ICD-9 and ICD-10

In addition to my response to the question raised by Rep. Pallone, I wanted to provide additional information in response to questions from several members of the Subcommittee asking whether health plans might “dual-track” claims and other transactions for a period of time after the October 1, 2015 implementation date. In other words, could health insurers, self-funded employer plans, and government programs continue to accept transactions coded in either ICD-9 or ICD-10 for a period of time until all providers were willing to come into compliance with the new requirements? As discussed below, such dual-tracking would be extremely costly and difficult to implement, especially given the short time frame between now and October 1st.

To frame this discussion, it is important to note that health plans conduct millions of electronic health care transactions on a daily basis – and each health plan exchanges this data electronically with hundreds if not thousands of external trading partners (e.g., providers, vendors, clearinghouses) and internal end-users (e.g., claims processing, provider relations, customer services). Further, the codes impact almost every internal system that health plans use in their day-to-day business operations. As a result, requiring health plans to process one vs. two code sets for any period of time after October 1st will have a significant and very negative impact on health plan operations. We have included a chart with this letter demonstrating the complexity of utilizing two code systems and the impact on health plan administrative and operational systems.

Health plans will continue to accept and process claims and other transactions using ICD-9 codes for a period of time after October 1st but only for claims with a date of service prior to that date. This limited run-out of claims is not expected to last beyond a short period of time for a very small number of transactions. Continuing to pay claims using ICD-9 codes with dates of service before October 1st is very different from having to accept either ICD-9 or ICD-10 coded transactions for a period of time based on a provider’s decision of what codes to use.

Our members have identified specific concerns with any requirement to dual-track transactions:

- Complexity and administrative challenges from maintaining two systems to process claims and other transactions with different business rules depending on the codes used.
- Difficulty in reporting information (e.g., HEDIS), analyzing data, and tracking payments and patient outcomes given the differences between ICD-9 and ICD-10 coding systems.

- Impact on fraud and abuse detection resulting from claims mixing the two code sets.
- Challenges to medical management, care coordination, and disease management programs due to a lack of uniform codes assigned to the diagnoses and procedures for an individual patient or group of patients.
- Increased potential for provider and payer confusion as well as processing and payment errors because providers, office management systems, coders, clearinghouses, and health plans will be switching between two different coding systems.
- Conflicts regarding the performance of health care activities such as quality assurance and disease management due to different providers submitting either ICD-9 or ICD-10 codes for the same diagnosis or treatment.
- Complications from mixed Diagnostic Related Group (DRG) using both code sets. DRGs combine medical “products” (e.g., an appendectomy) based on factors such as patient age and gender and the diagnosis/procedure code for payment purposes. Currently, DRGs are based on either the ICD-9 or ICD-10 assigned codes and it would be difficult to develop and test “mixed” code DRG logic.
- Having to continue provider outreach and training and other implementation activities beyond the October 1st implementation date leading to higher costs and resource demands.

In addition to these issues, our members relate two overall concerns with having to maintain two distinct coding systems over time. First, our members estimate the cost for maintaining two coding systems could be as high as \$10 million per health plan depending on the length of the delay in a full transition to ICD-10 and the number of providers that choose to continue use of ICD-9. This cost is on top of the hundreds of millions of dollars our industry has already expended to support ICD-10 implementation and the millions of additional dollars resulting from the multiple delays of the compliance date (several of our members who operate on a national basis estimate the delays have cost them upwards of \$100 million).

In addition, our members are concerned there will not be sufficient time prior to October 1st to establish and test dual processing systems. As noted, health plans support millions of daily transactions with a significant number of trading partners and internal end-users. Changing the current implementation plan which relies on a clean switch over to ICD-10 to a new, complex, untested, and administratively burdensome dual-track process cannot be done in a few months.

For these reasons, we believe the dual-tracking of transactions after October 1st would be significantly damaging to our health care system and should not be adopted.

