Statement of the American Medical Association
to the
National Committee on Vital and Health Statistics'
Subcommittee on Standards
Regarding the Planning and Implementation of the
Updated HIPAA Transactions and Code Sets
Presented by Nancy W. Spector

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Good morning, I am Nancy Spector, Director of Electronic Medical Systems, at the American Medical Association (AMA). I am also the chair of the National Uniform Claim Committee. The AMA thanks the National Committee on Vital and Health Statistics' (NCVHS) Subcommittee on Standards for inviting our input on implementation strategies for the updated Health Insurance Portability and Accountability Act (HIPAA) transactions and code sets.

The AMA strongly supports upgraded HIPAA transactions to improve the efficiency and effectiveness of the health care system. We recognize that the business needs of health care are continually evolving, and therefore, the standards through which data exchange occurs need to be continually modified and updated. Without ongoing modifications, the standards and implementation guides become outdated and may no longer support the administrative needs of physicians or provide the benefits to be gained through electronic transactions.

As for the move to ICD-10 for diagnosis coding and inpatient hospital procedure coding, the AMA has continued to emphasize the significance of this change for the health care industry. Implementing ICD-10 is not just a technology project. It will impact many business processes within a physician's practice, including documentation of a patient's visit, research activities, public health reporting, quality reporting, and administrative transactions. We continue to have concerns about the costs and aggressive timeline for implementing ICD-10 in the wake of the implementation of the 5010 transactions and other competing federal requirements and priorities.

Outreach Efforts for HIPAA Transactions/5010

Since the publication of the final rule naming the 5010 transactions, the AMA has taken efforts to outreach and plan for physicians' needs on the implementation of the 5010 transactions. Below is an overview of our outreach efforts to date.

Web: We began by revising our AMA Web site content to provide information on the regulatory requirement and an overview of the 5010 transactions. The Web address for our 5010 transaction related information is www.ama-assn.org/go/5010. We intend for our Web site to be the main location for our resources. The Web site also includes links to the Centers for Medicare & Medicaid Services (CMS) Web site and we intend to promote CMS' outreach and education.

Articles: An article, titled "An Update to the Current Version of Electronic Administrative Transactions Is on the Horizon: Understanding How This Impacts Your Practice," was published in the June *CPT Assistant Bulletin*. The article is available on our AMA Web site with the title "7 Steps Practices Can Take Now to Prepare for 5010." It was also sent to an AMA listserv of state and specialty societies.

Survey: In August 2009, the AMA conducted a survey of the state and specialty societies to gather information on what efforts they were planning with their members related to the 5010 transactions. We also considered the survey to be an educational tool since it alerted them to our efforts and the need to

provide information to physicians. The response rate was low; eighteen state and specialty societies responded. Only two indicated they had received any requests from their members for resources on the implementation of the 5010 transactions. Ten responded that they have provided resources on implementing 5010. The resources included messages about the requirement to implement 5010; articles providing details on implementing 5010; written materials, presentations, and webinars on what practices need to do to implement 5010; and links to the AMA Web site. We intend to conduct more surveys of the activities being done by the state and specialty societies and coordinate our efforts with them on educating physicians about the 5010 implementation.

Presentations: We have provided two presentations on the 5010 transactions, along with the topic of the ICD-10 code sets. The first presentation was held at the CPT Annual meeting on October 16, 2009. The second presentation was at the AMA CPT Symposium on November 12, 2009. Both presentations gave an overview of the regulatory requirements, information on the transactions and code sets, and information on the work to implement them.

Fact Sheet Series: In November 2009, the AMA distributed to its membership the first two fact sheets in a series of six addressing the implementation of 5010. The first fact sheet provides background information on HIPAA and the standard transactions. The second fact sheet is an overview of the tasks and estimated timeframes needed to implement the 5010 transactions. Additional fact sheets on understanding the HIPAA terminology, identifying the changes in the 5010 transactions, testing the new transactions, and enforcement of the HIPAA transactions will be distributed over the next several months.

Project Planning Template: The template, a resource to be released shortly, will be a tool that will walk a practice through the detailed activities it will need to do to implement the 5010 transactions. It provides space for the practice to document their work and track their coordination efforts with their vendors, clearinghouses, and payers. This tool will complement other tools we have to support physician practices on the criteria they need to consider when selecting a practice management system.

Collaboration with Other Industry Groups: The AMA is also actively participating in the Workgroup for Electronic Data Interchange (WEDI) and work they are doing related to implementing 5010. We have sent, and plan to continue sending, announcements to our state and specialty listservs of WEDI and CMS education and surveys. In October 2009, we sent information on a WEDI survey assessing the industry's readiness and encouraged physicians to respond. We are also reaching out to other organizations in the industry, including the Medical Group Management Association (MGMA) and CMS, about their efforts with the implementation of 5010.

Other Outreach: Additional activities we have planned for the 5010 implementation include developing a comprehensive toolkit of our materials, conducting surveys of physicians to determine their readiness, revising our HIPAA transactions books, and continuing to message on the need to be prepared for the compliance deadline.

Outreach Efforts for HIPAA Code Sets/ICD-10

To date, the AMA's outreach efforts for the ICD-10 code sets have been more limited than our work on the 5010 transactions. Our intent is to provide a complement of resources for the 5010 transactions over the next several months and then focus our efforts on ICD-10. When appropriate, we have been combining our messages on the 5010 and ICD-10 implementations. Below is an overview of our outreach efforts to date.

Web: After the release of the ICD-10 final rule, we updated our AMA Web site with an overview of the regulatory requirement and a brief explanation of the changes from ICD-9 to ICD-10. Our AMA Web

site, www.ama-assn.org/go/ICD-10, provides links to other organizations, including the National Center for Health Statistics (NCHS), American Academy of Professional Coders (AAPC), American Health Information Management Association (AHIMA), American Hospital Association (AHA), CMS, and WEDI. We have provided links to the CMS presentations and articles, as well as the General Equivalence Mappings (GEMs).

Articles: An article, titled "Preparing for the Conversion from ICD-9 to ICD-10: What You Need to Be Doing Today" is available on our Website. It is expected to be published in the *CPT Assistant Bulletin* this spring. The article was also sent to an AMA listserv of state and specialty societies.

Survey: The survey the AMA conducted in August 2009 of the state and specialty societies included questions about their efforts related to ICD-10. Of the eighteen that responded, five indicated they had received requests from their members for information on ICD-10. Nine responded that they have provided resources on ICD-10. The resources included messages about the requirement to implement ICD-10; articles on implementing ICD-10; written materials, presentations, and webinars on what practices need to do to implement ICD-10; and links to the AMA Web site. Again, we intend to conduct more surveys of the state and specialty societies' activities and coordinate our efforts on educating physicians about the ICD-10 implementation.

Other Print and Electronic Outreach: We have been, and plan to continue, using various AMA publications and communication vehicles to provide information on the ICD-10 implementation, as well as the 5010 implementation.

Presentations: As mentioned above, the AMA has also held two presentations already on the ICD-10 implementation work, along with the 5010 transactions.

Collaboration with Other Industry Groups: The AMA continues to engage in industry activities related to the implementation of ICD-10. We are participating in WEDI's work where we are able to provide the physician's perspective on ICD-10 and convey WEDI information to our members and state and specialty societies.

The AMA has reached out to many organizations that are necessary partners for ensuring a successful transition to ICD-10. On December 4, 2009, the AMA hosted a stakeholder meeting with the Blue Cross Blue Shield Association (BCBSA), America's Health Insurance Plans (AHIP), American Clinical Laboratories Association (ACLA), American Dental Association (ADA), Health Information Management Systems Society (HIMSS), Healthcare Billing and Management Association (HBMA), National Council for Prescription Drug Programs (NCPDP), Emdeon, The SSI Group, MGMA, AHA, AHIMA, and AAPC. The meeting was the first in what we hope to be many in which industry leaders come together to discuss the concerns and barriers we are facing with implementing ICD-10. We hope to work together as a group to develop consensus approaches to solving issues we encounter.

Other Outreach: Throughout 2010, the AMA will develop more resource materials that will be distributed to physicians and the state and specialty societies. We intend to develop an ICD-10 fact sheet series to give an overview of ICD-10 and the regulation, compare ICD-9 and ICD-10, review crosswalking and the GEMs, review ICD-10 impacts on practices, and discuss testing and system changes for ICD-10. We plan to develop an ICD-10 implementation project plan template, similar to the 5010 tool. The vendor resource tool described above will be expanded to include ICD-10. We will combine these resources into an ICD-10 implementation toolkit. We are planning to develop an ICD-9 – ICD-10 conversion tool that will more specifically meet the needs of physicians. Finally, we are looking into developing a webcast series that will be focused on what physicians need to do to implement ICD-10.

The AMA will continue to look for new opportunities and methods for our outreach and education efforts. We welcome any suggestions that you or others may have for us.

Barriers to Implementation

A year ago, if asked about barriers to implementing the 5010 transactions and ICD-10, we would have talked about the inherent complexities with undergoing and synchronizing two large systems changes within a relatively short period of time among physicians, other health care providers, payers, clearinghouses, and vendors. If that was not enough, physicians are now facing other major priorities with imminent deadlines. Meaningful use for electronic health records (EHR), additional HIPAA security and privacy requirements resulting from the passage of the "American Recovery and Reinvestment Act" (ARRA), and e-prescribing are a few of these other priorities. It is important to note that all of these new federal mandates and priorities compete for the same physician, clinical and administrative staff, and financial resources.

The following is an overview of the deadlines associated with each of these requirements, as they are known today.

- September 23, 2009 – Compliance date for breach notification rules (Enforcement deadline: February 22, 2010)
- January 1, 2011 – Payment date for first level of EHR meaningful use criteria
- January 1, 2012 – Compliance date for 5010 transactions
- January 1, 2013 – Payment date for second level of EHR meaningful use criteria
- October 1, 2013 – Compliance date for ICD-10 code sets
- January 1, 2015 – Payment date for third level of EHR meaningful use criteria

Cost is always a barrier to implementing changes in physician practices. Today, physicians face a continual decline in their reimbursement. Without a fix to Medicare's sustainable growth rate formula, physicians face a 21 percent cut in payments on January 1, 2010. Physicians who have not adopted e-prescribing systems face a one percent payment penalty starting in 2012, increasing to two percent in 2014. In 2015, physicians who have not adopted an EHR system that meets the meaningful use criteria will see a one percent decrease in their Medicare payments and this will rise to three percent in 2017.

A study conducted by Nachimson Associates, released in October 2008, indicated that the first year cost of implementing ICD-10 in a typical small physician practice, with three physicians and two administrative staff, could be as high as $83,000. This cost is just for ICD-10 and does not include the costs for implementing the 5010 transactions and the other requirements being mandated. As with all of the mandates, we are concerned about physicians realizing the return on investment that is projected with each initiative. Because fifty percent of physician practices have less than five physicians, and yet account for eighty percent of outpatient visits, the AMA is very sensitive to issues that impact physicians' resources, costs, and reimbursement.

The AMA is concerned with what appears to be a lack of coordination among the various government bodies as to what requirements they are imposing, how the deadlines for the requirements are converging, and the impact they are having on physicians. **The AMA urges NCVHS to recommend to the Secretary that one entity within the government track the various requirements and make recommendations to the appropriate overseeing bodies about the realistic timeframes for sequencing and completing all of the incentive and/or penalty programs and mandates.**

Issues Identified with the HIPAA Transactions

The AMA's vision is to see physicians and other health care providers have access to administrative information before or at the time of service for every patient or health plan, following the submission of either batched or real-time transactions as best meets the needs of the patients and streamlines the physician's workflow.

Enforcement of the HIPAA transactions and codes sets needs to ensure that covered entities comply with all standard transaction guide instructions and that data is reported accurately and to the highest level of specificity available, not that it only be syntactically correct. Until the information being conveyed electronically eliminates the need for follow up phone calls and other manual processing, administrative simplification will remain an unfulfilled promise. Moreover, the information in the electronic standard transactions must be at least as robust as the information contained in the current paper claim still used by many physician offices. As long as the paper transactions provide more useable information for these physicians, they will not see value in adopting the electronic transactions.

To achieve value for the payer there must be physician adoption. Physicians will adopt HIPAA standard transactions when we have a fully automated claims payment and reconciliation cycle that provides all relevant information about the payer, the payer's agents, and the fee schedule amount on all relevant transactions in unambiguous terms. Today, physicians are unable to clearly identify some or all of the following:

1. The entity financially responsible for payment;
2. The entity responsible for administering the claim;
3. The entity that owns the contract with the physician applicable to the claim;
4. The fee schedule that applies to the claim;
5. The specific plan/product type;
6. The location where the claim is to be sent; or
7. Any applicable secondary or tertiary payers that may have financial responsibility for all or part of the claim.

Without a standard method of identification of these variables, patients, physicians and other health care providers must either contact the health plan directly and request the information before patient treatment is delivered, and/or be forced to contact the health plan after payment is rendered to ascertain if the contractual agreement was fulfilled. Ambiguity and manual intervention contributes to higher costs for everyone.

The AMA has been involved with the Accredited Standards Committee X12's (ASC X12) work on the health care transactions for many years, although our focus has been on the claims transaction. In recent years, we have begun to work more closely on the other transactions. We are finding a need for more specific information that is not present or not required in the 5010 version. Without this information, the physician practice will continue to have to manually intervene, which decreases the value of using the transactions. For example, there are situations when the information returned in the remittance advice cannot identify the unique, provider-specific insurance plan code needed to post the payment automatically. The transaction needs to require additional information, the class of contract code, in these situations. This issue was not resolved in the 5010 transaction and will remain an issue for physicians. We intend to work with X12 to have the necessary changes we have identified made in the next version of the transactions. Meanwhile under 5010, physicians will not have the fully automated revenue cycle system they desire. We see this as a barrier to physicians adopting the HIPAA transactions.

The variability with requirements within the HIPAA transactions continues to be an issue; one that will hinder physicians' adoption of the transactions. In version 4010, situational data elements were left to the payers' discretion as to whether or not they had to be reported by the physician, which resulted in each payer developing its own companion guide. Small physician practices are simply unable to handle the level of complexity resulting from each of its payers having a different set of rules for each transaction. They are forced to use clearinghouses if they wish to submit transactions electronically. We are aware that the 5010 transactions have tighter language about when situational data is or is not reported. We are cautiously optimistic about the impact the new language will have on decreasing the reporting variability that exists today.

Standardization of the CPT guidelines and coding conventions would also likely increase physician adoption of the HIPAA transactions due to the reduction of complexity and confusion with CPT coding. Without the adoption of the CPT guidelines and conventions, which are developed through the same rigorous process as the code development, each payer has developed its own instructions for CPT coding. Standardization would contribute to a measurable decrease in the administrative costs of appeals for payers and the cost incurred as a result of incorrect claim submissions for physicians, who currently struggle with conflicting payer instructions. The AMA's Private Sector Advocacy is very involved in tracking these issues and their impacts on physicians. White papers that provide further detail on these issues are available on the AMA's Web site www.ama-assn.org/go/simplify.

T**he AMA recommends better enforcement of the HIPAA transactions by CMS to ensure payer compliance.** Covered entities need to comply with all transaction instructions and report data accurately and to the highest level of specificity. Until the information conveyed electronically eliminates the need for follow up phone calls and other manual processing, physicians will not fully adopt all of the HIPAA transactions. We are very pleased with CMS' intentions to increase enforcement in this area. Attached is the AMA's response to CMS' recent Request for Information on enforcement of HIPAA transactions and code sets further detailing our recommendations on this topic.

Priorities for Physicians During Implementation

The AMA sees three key priorities for physicians' planning and implementation of the 5010 transactions and ICD-10. They are working with their vendors, working with their trading partners, and coordinating other electronic data interchange (EDI) requirements.

Vendors: First, physicians need to work with their vendors. Physician practices are largely dependent on their vendors to provide them with any necessary system and/or software upgrades they need. Physicians need to contact their vendors early and have a clear understanding of what will be happening with the upgrades to their systems. Physicians need to be asking their vendor questions, such as:

- "Will you be upgrading my current system to accommodate the 5010 transactions and ICD-10?" Some vendors may not be upgrading certain systems.
- "Can my current system accommodate the 5010 transactions and ICD-10?" Some practices' systems may not be able to be upgraded for 5010 or ICD-10. They may be too old to accommodate the changes.
- "Will there be a charge for the upgrade?" For some practices, the cost of regulatory upgrades may be included in their contract with the vendor, but for others, there may be charges.
- "When will the upgrades be available and when will the installation to my system be completed?" There will likely be a period of time between when the vendor has the upgrades ready and when they can install them in the practice.

Trading Partners: The second priority for physicians is to work with their trading partners; their billing service and clearinghouse, if they use either, and their payers. The transition from the 4010 to 5010 transactions will require a well choreographed effort by all involved. Not all trading partners will be ready to exchange 5010 transactions or transactions containing ICD-10 codes at the same time. Physician practices will need to conduct testing with potentially dozens of trading partners. This work alone will take hours of the practice's staff time. The testing involves communicating with the other entity to set up the testing, generating and sending the test transactions, reviewing the received test transactions, and reviewing reports on the testing to identify any issues. A concern is that the work to complete the testing will be too complex for a practice and it will simply overwhelm them. This could result in testing not being done, issues with the systems not being addressed, and the inability to send and receive 5010 transactions or ICD-10 codes after the compliance deadline.

The AMA strongly recommends that CMS and other payers communicate early and often with the physicians with whom they contract on the need to test the 5010 transactions and ICD-10. We also request that the clearinghouses and payers develop simple testing procedures that will reduce the burden on the physician practices. We hope that straightforward and thorough guidance can be provided to the industry on how to complete the large tasks of transitioning first to the 5010 transactions and then to ICD-10. The reality is that practices will be faced with this implementation work with their vendors for three years, at a minimum. First, they need to transition to the 5010 transactions and then they need to complete the ICD-10 conversion. Some work for implementing ICD-10 may overlap with the work to implement the 5010 transactions, but overall, the work with pose a large burden on practices.

Other EDI Requirements: Finally, practices need to take this time to consider all of the various EDI requirements, as mentioned above. They need to understand how their current system will accommodate not just the 5010 transactions and ICD-10, but also "meaningful use," security and privacy, e-prescribing, and quality reporting. The worst that can happen is for practices to go through the time and expense of upgrading their system to meet the 5010 transactions and ICD-10 requirements only to find out it does not meet the needs for other requirements.

Risk Areas with Implementation

The AMA believes that there are several risks with the implementation of the 5010 transactions and ICD-10, which must be overcome to ensure successful transitions. The concerns include vendor readiness, the ability of physicians' systems to accommodate 5010 and/or ICD-10, the ability for the industry to process 4010 and 5010 transactions, crosswalking and/or mapping of the ICD-9 and ICD-10 code sets, and other changes that will be required as a result of the move to ICD-10.

Vendor Readiness: Our first concern is with vendor readiness. Physician practices are largely dependent on their vendors to provide the necessary system and software upgrades. If the vendors do not have their products ready early enough, or do not complete their installation work in time, physicians' systems simply will not have the capability to send and receive the 5010 transactions or ICD-10 codes. Physicians cannot receive their upgrades just in time for the 5010 and ICD-10 compliance deadlines. They need the upgrades completed well in advance of the deadlines so they can complete internal and external testing to ensure that the transactions will work properly. For the same reasons, payer readiness is just as critical.

Systems' Abilities: Another concern is that physicians will find that their system is too old and will not accommodate the necessary upgrades needed for the 5010 transactions or ICD-10. The practice will then need to go through the process of purchasing a new system. As describer earlier, the upcoming demands, including reporting and demonstrating meaningful use of EHRs and e-prescribing will make it

complicated for physicians to identify a system that will meet their practice's needs and these various requirements. The process of choosing a new system will be time consuming and costly.

Processing Abilities: A larger and more widespread risk with implementation is the ability of everyone to handle processing of 4010 and 5010 transactions at the same time. As discussed earlier with testing, not all entities will be ready to transition to the 5010 transactions at the same time. If a practice's system is unable to do dual processing, or if any of their trading partners are unable to, the practice will need to decide if it will wait until one date to move to the 5010 transactions for all of its trading partners. Alternatively, the practice may need to migrate to 5010 for those trading partners that can process them and use a clearinghouse or drop to paper and manual processes for those trading partners that are not ready for 5010, which will be an overwhelming burden. We see this migration process as being very complex and will require good communication and coordination among trading partners.

As of January 1, 2012, there is a risk that not all of the industry will be prepared to send and receive 5010 transactions. If any of a physician's payers or clearinghouses are not ready, the physician will have to work with them to determine what process will be taken in order for the claims and other transactions to continue to flow through the system. Again, a major burden will be placed on physicians if they have to use a clearinghouse or drop to paper or manual processes to work with unprepared trading partners. The lack of readiness will also likely impact timely payments to physicians. The AMA intends to message to physicians to establish a line of credit prior to both the 5010 and ICD-10 compliance deadlines in case there are disruptions in their cash flow as a result of claims that are not being processed. As we learned during previous HIPAA implementations, most recently with the National Provider Identifier (NPI), there is a strong likelihood for claims processing and cash flow interruptions. As a result, an untold number of physicians did not receive Medicare reimbursement for months causing severe financial hardship. **The AMA strongly recommends that NCVHS recommend to the Secretary that Medicare create clear guidelines on cash advances and that the policy be made widely available to all physicians, something that did not happen with the transition to the NPI.**

A related issue to processing abilities is the non-covered entity status of the property and casualty and workers' compensation industries. These payers were excluded from the HIPAA transactions and code sets regulation, so they are non-covered entities. We are hearing that many are unlikely to convert to using ICD-10, which means that physicians will need to maintain the ability to code these claims in ICD-9 placing yet another burden on them. We are raising this as a concern and recognize that there would need to be a statutory change to require these non-covered entities to comply with the transactions and code sets regulations.

Mapping/Crosswalking: We have concerns about how the ICD-9 and ICD-10 codes will be mapped to one another. Our understanding is that the GEMs provide a basic map between the ICD-9 and ICD-10 codes, but entities, mostly payers, may have their own maps for matching ICD-9 and ICD-10 codes, particularly where there are one-to-many code matches. If payers develop their own maps to do this, each payer may map the codes differently. Physicians may then bear the burden of having to know which codes to submit to different payers. We have also heard that some payers will not be converting their claims processing systems to ICD-10 in time for the compliance deadline. Instead, they will take in the ICD-10 code from the physician and crosswalking it to an ICD-9 code to send the claim through their processing system. We are still exploring the issues with crosswalking and mapping and the impact it could have on physicians.

Crosswalking and mapping of the ICD code sets was a main agenda item for the stakeholder meeting we hosted on December 4, 2009. The payer representatives at the meeting reported that they are working with their constituents on crosswalking and mapping and how they might be used to meet their business needs. Provider organizations, including the AMA, MGMA, ACLA, and HBMA, expressed the desire to

have one map used throughout the industry. This stakeholder group plans to continue meeting periodically and the topic of crosswalks and maps will be further discussed. **The AMA urges NCVHS to recommend that a single, mandated map be named for use by all covered entities in the industry.**

Other Changes: We are aware there are numerous business process changes that will need to occur with the implementation of ICD-10. We would like to highlight two changes about which we have specific concerns.

The first is changes that will occur with payers' medical payment policies. Payers' payment policies are tied to the diagnosis codes. Payers will need to rewrite their policies for the ICD-10 codes. If payers decide to crosswalk the ICD-10 codes to the ICD-9 codes in their existing policies, variations will again be introduced as to which code or codes will be recognized by the payer. This variation will potentially impact physician payment.

Our second concern involves the necessary yet challenging task of "retooling" quality measures for capture by EHR systems. Hundreds of quality measures are available and in use today for claims-based reporting. Specifications for these measures are comprised of ICD-9 and CPT codes. Therefore, current work to "re-tool" existing quality measures for electronic capture is predicated on ICD-9 codes. The mandated transition to ICD-10 will not only require all claims based quality measures be revised to accurately reflect new ICD-10 codes, but those measures that were already "re-tooled" for electronic capture must also be reformatted to reflect ICD-10 codes. This work requires intense staff and financial resources to accurately revise both the claims based and electronic specifications, as well as time to adequately test the validity of these specifications within physician offices. Without testing, variations in the diagnosis codes used in the quality measures will place a data collection burden on physicians and may impact scoring of the measures. It is imperative that the transition to ICD-10 does not ignore the important work of quality measure development and testing.

Conclusion

The AMA appreciates the opportunity to participate in these hearings and is pleased to see NCVHS taking an early and active initiative in understanding the industry's progress and key barriers with implementing the 5010 transactions and ICD-10 code sets that must be overcome. A transition of this magnitude will require a workable implementation process and timeline for all HIPAA covered entities and their health care partners, and comprehensive outreach and education initiatives to support health care providers, especially small physician practices, throughout this complex, costly move to 5010 and ICD-10. We look forward to providing further input on this important work in the future.