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May 10, 2012

Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Administrative Simplification: Change to the Compliance Date for ICD-10-CM and ICD-10-PCS Medical Data Code Sets; CMS-0040-P; RIN 0938-AQ13

Dear Acting Administrator Tavenner:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am pleased to submit the following comments in response to the Centers for Medicare & Medicaid Services' (CMS) proposed rule on the postponement of the compliance date to October 1, 2014, for the move to the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding, including the Official ICD-10-CM Guidelines for Coding and Reporting, and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding, including the Official ICD-10-PCS Guidelines for Coding and Reporting. The AMA will be issuing a separate comment letter on the proposed standard for a unique health plan identifier.

CMS proposes that the compliance deadline for ICD-10-CM and ICD-10-PCS be changed from October 1, 2013 to October 1, 2014. As you are aware, the AMA's House of Delegates (HOD) approved new policy at our November 2011 meeting to repeal the move to ICD-10 so that physicians and other stakeholders could assess an appropriate alternative to such a costly, burdensome regulatory requirement. The AMA's HOD passed this policy because physicians are overwhelmed with the prospect of the tremendous administrative and financial burdens of moving to a diagnosis code set with 68,000 codes. In addition, the federal government is also currently implementing a number of inadequately aligned programs that are placing additional expenses and requirements on physician practices. Physicians are engaging in these programs at the same time as they are trying to transition to new models of payment and delivery reform. These burdens physicians are facing are compounded as they face the ongoing threat of steep Medicare physician payment cuts due to the flawed sustainable growth rate (SGR), including a 31 percent cut (according to the Medicare Trustees) on January 1, 2013, along with a 2 percent deficit reduction sequester beginning in January 2013.

While we welcome the proposed extension in the compliance deadline for ICD-10, we strongly urge CMS to further extend the ICD-10 deadline at a minimum to October 1, 2015. A two-year delay of the compliance deadline for ICD-10 is a necessary first step. This postponement period

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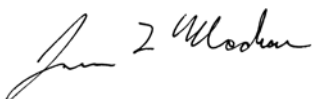
would provide CMS with adequate time to pursue a much needed cost-benefit analysis of the full ICD-10 move that covers the administrative and financial impact of the ICD-10 move on physician practices. During this time, we also urge CMS to institute a process to engage all relevant stakeholders including physicians to assess whether an alternative code set approach is more appropriate than the full implementation of ICD-10. While a number of other countries have implemented ICD-10, they have done so with a modified version of the code set and often with substantial government support. CMS needs to give full consideration to all the issues. A year's delay does not provide CMS with adequate time to fully examine the appropriate scope of ICD-10 and true costs to physician practices. **If stakeholders cannot reach consensus on this matter during this two-year delay period, then the move to ICD-10 should be postponed indefinitely.**

Implementing ICD-10-CM alone (outpatient diagnosis codes) requires physicians and their office staff to contend with 68,000 codes—a five-fold increase from the current 13,000 codes. This is a massive administrative and financial undertaking for physicians, requiring education, software, coder training, and testing with payers. Depending on the size of a medical practice, the total cost of implementing ICD-10 ranges from \$83,290 to more than \$2.7 million. In addition to the significant administrative and financial challenges associated with the move to ICD-10, there is dissent in the physician and informatics community regarding whether ICD-10 is the appropriate replacement for ICD-9. Moreover, experiences in Canada and studies on the transition to ICD-10 show a severe risk for claims processing and payment disruptions. CMS' own assessment indicates that there are considerable financial and administrative risks to physicians undergoing a transition of this magnitude. There is also considerable concern that ICD-10 will cause severe financial and workflow disruptions if implemented simultaneously with new electronic health record (EHR) systems.

Physicians are also overwhelmed with the simultaneous implementation of multiple health IT programs and are being forced to prioritize which initiatives they are able to meet based on the potential incentives and penalties and their impacts on their reimbursement. These programs include the value-based modifier, penalties under the electronic prescribing (e-prescribing) program, physician quality reporting system (PQRS) and EHR meaningful use incentive and penalty programs. Physicians are being required to meet separate requirements under the three overlapping health IT programs and have been and will be unfairly penalized if they decide to participate in one program over the others, since the three health IT incentive programs include financial penalties for noncompliance. We request that CMS better align the disparate program requirements to reduce the burdens of participating in them.

Thank you for considering our recommendations on ICD-10. Should you have questions or require additional clarification about these comments, they may be directed to Mari Savickis, Assistant Director, Division of Federal Affairs, at 202-789-7414 or mari.savickis@ama-assn.org.

Sincerely,

A handwritten signature in cursive script, appearing to read "James L. Madara".

James L. Madara, MD