



# **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**

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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.