

March 4, 2015

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

Dear Acting Administrator Slavitt:

The undersigned organizations are writing to you concerning the agency's implementation plans for moving to ICD-10, a code set named under the Health Insurance Portability and Accountability Act (HIPAA) that will be required for use by physicians and others starting October 1, 2015. The transition to ICD-10 represents one of the largest technical, operational, and business implementations in the health care industry in the past several decades. Given the profound impact this will have on physicians, we have a number of concerns that do not appear to be addressed by the Centers for Medicare & Medicaid Services' (CMS) current transition plan.

### **Testing**

We appreciate the training, educational tools, and other efforts by CMS to prepare physicians and other health care entities for the ICD-10 transition. 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, is limited in that it 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.

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It would help for CMS to explain in detail the errors that were encountered and what steps need to be taken to correct these problems.

**Table 1. Medicare Acknowledgement Testing Results**

	<b>March</b>	<b>November</b>
Total Number of Claims Tested	127,000	13,700
Participants (A/B providers)	2,600	500
Percent of overall A/B providers <sup>i</sup>	.16%	.03%
Percentage of Claims Accepted	89%	76%
Percent of overall Medicare claims submitted annually <sup>ii</sup>	.01%	.001%

<sup>i</sup> = According to CMS' Fast Fact, November 2014, there are 1,618,419 Medicare Part A&B providers

<sup>ii</sup> = According to CMS' Fast Fact, November 2014, there are 1,213,368,119 claims processed annually

We appreciate that CMS agreed to conduct more robust end-to-end testing in which the claim will be accepted, processed, and a remittance advice generated. We are worried, however, that the testing may not provide an accurate depiction of provider readiness given the small sample size. CMS is only planning on testing with 850 claims submitters per testing week for a total of 2,550 testers. This represents a very small fraction of all Medicare providers and an even smaller universe of claims submitted each year. In addition, because the testing participants are volunteers, it is possible that those most confident of their preparation self-selected into the testing program—so that the numbers of successful efforts are not representative.

In addition, the first week of end-to-end testing was completed the last week of January 2015 and the results of the testing were just released. The data from this testing show only a broad overview of the number of claims received (14,929), number of claims accepted (12,149), acceptance rate (81%), and partial information about the reasons and percentages of rejected claims. Again, the acceptance rate was still well below average, and we continue to be concerned about the limited scale of testing being performed. **Accordingly, we strongly urge CMS to release more detailed end-to-end testing results broken out by the type and size of providers who tested, number of claims tested by each submitter, percentage of claims successfully processed, and specific details about problems encountered.**

### **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

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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) and Meaningful Use (MU) quality reporting periods are based on the calendar year (January 1-December 31, 2015). Many of the MU and 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. CMS has not discussed how it plans to address and correctly tabulate quality performance reporting metrics after the transition to ICD-10.

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.

In addition to our concerns noted above regarding testing, Medicare's end-to-end testing is not expected to evaluate the impact on quality measurement or Medicare's ability to properly calculate measures. **We strongly urge CMS to: 1) provide details on how it plans to ensure that the measure calculations for these programs are not adversely impacted by the transition to ICD-10; and 2) ensure cross-walks do not attribute increased costs to a physician's VBM score when switching to ICD-10. Any changes in measure specifications from ICD-9 to ICD-10 should demonstrate stability and be budget neutral during the transition.**

### **Risk Mitigation**

#### *Contingency Plans and Advance Payments*

Previous HIPAA mandates—such as the National Provider Identifier (NPI) and the upgrade to Version 5010 transactions—resulted in significant claims processing disruptions that caused physicians to go unpaid for weeks and sometimes months. These implementations were less complex than ICD-10 and still resulted in significant disruptions.

By CMS' own analysis, one of the most significant risks to moving to ICD-10 is the likelihood for claims processing and cash flow interruptions. It is therefore vitally important that CMS is prepared with extensive contingency plans in the event that these feared disruptions occur.

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In particular, we have asked CMS to help mitigate these risks by granting “advance payments” (which are nothing more than reimbursement outside of the normal claims processing system for services already rendered, such as paper checks) to physicians experiencing a dire financial hardship as a result of the change to ICD-10, particularly if the issue originates on Medicare’s end. We appreciate the Administration’s indication to use advance payments; however, we urge CMS to publicize and finalize this policy.

### *Software Upgrades*

Physicians who bill Medicare are required to use a certified electronic health record (EHR); otherwise, they face a financial penalty under the MU program. The Version 2014 certified software is required to accommodate ICD-10 codes; yet, many EHR vendors were behind in delivering upgrades to physicians in 2014 to meet the MU program. There is no data that indicates when vendors will be ready to deliver the ICD-10 upgrades and what help will be available for physicians whose vendors decided not to certify to 2014. **We strongly urge CMS, together with the Office of the National Coordinator for Health Information Technology (ONC), to study this issue and make information about vendor readiness available.**

### *Specificity of Codes and Audit Plans*

There continue to be questions in the physician community concerning the specificity of codes required for inclusion on Medicare claims following the transition to ICD-10. CMS officials have stated that, absent indications of potential fraud or intent to purposefully bill incorrectly, CMS will not instruct its contractors to audit claims to verify that the most appropriate ICD-10 code was used. There is also general concern about how physicians will be audited as they learn to use the new code set. **We urge CMS to: 1) confirm and broadly educate stakeholders and contractors that claims will not be audited simply for code specificity; and 2) to instruct contractors that they are prohibited from engaging in audits that are only predicated on code specificity.**

### **Conclusion**

By itself, the implementation of ICD-10 is a massive undertaking. The undersigned organizations remain 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 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

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investments to improve quality. We appreciate the opportunity to offer this perspective and these recommendations and look forward to further dialogue on this issue.

Sincerely,

American Medical Association  
American Academy of Allergy, Asthma & Immunology  
American Academy of Dermatology  
American Academy of Emergency Medicine  
American Academy of Facial Plastic and Reconstructive Surgery  
American Academy of Family Physicians  
American Academy of Neurology  
American Academy of Ophthalmology  
American Academy of Otolaryngic Allergy  
American Academy of Otolaryngology— Head and Neck Surgery  
American Association of Clinical Endocrinologists  
American Association of Hip and Knee Surgeons  
American Association of Neurological Surgeons  
American Association of Neuromuscular & Electrodiagnostic Medicine  
American Association of Orthopaedic Surgeons  
American Clinical Neurophysiology Society  
American College of Cardiology  
American College of Chest Physicians  
American College of Mohs Surgery  
American College of Occupational and Environmental Medicine  
American College of Osteopathic Internists  
American College of Osteopathic Surgeons  
American College of Physicians  
American College of Radiology  
American College of Rheumatology  
American College of Surgeons  
American Congress of Obstetricians and Gynecologists  
American Geriatrics Society  
American Orthopaedic Foot & Ankle Society  
American Osteopathic Association  
American Society for Clinical Pathology  
American Society for Dermatologic Surgery Association  
American Society for Gastrointestinal Endoscopy  
American Society for Radiation Oncology

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American Society for Surgery of the Hand  
American Society of Anesthesiologists  
American Society of Cataract and Refractive Surgery  
American Society of Cytopathology  
American Society of Dermatopathology  
American Society of Hematology  
American Society of Interventional Pain Physicians  
American Society of Retina Specialist  
American Urological Association  
College of American Pathologists  
Congress of Neurological Surgeons  
Heart Rhythm Society  
International Society for the Advancement of Spine Surgery  
Medical Group Management Association  
National Association of Medical Examiners  
North American Spine Society  
Renal Physicians Association  
Society of Interventional Radiology  
Society of Thoracic Surgeons

Medical Association of the State of Alabama  
Arizona Medical Association  
Arkansas Medical Society  
California Medical Association  
Colorado Medical Society  
Connecticut State Medical Society  
Medical Society of Delaware  
Medical Society of the District of Columbia  
Florida Medical Association Inc  
Medical Association of Georgia  
Hawaii Medical Association  
Idaho Medical Association  
Illinois State Medical Society  
Indiana State Medical Association  
Iowa Medical Society  
Kansas Medical Society  
Kentucky Medical Association  
Louisiana State Medical Society  
Maine Medical Association

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MedChi, The Maryland State Medical Society  
Massachusetts Medical Society  
Michigan State Medical Society  
Mississippi State Medical Association  
Missouri State Medical Association  
Montana Medical Association  
Nebraska Medical Association  
Nevada State Medical Association  
New Hampshire Medical Society  
Medical Society of New Jersey  
New Mexico Medical Society  
Medical Society of the State of New York  
North Carolina Medical Society  
North Dakota Medical Association  
Ohio State Medical Association  
Oklahoma State Medical Association  
Oregon Medical Association  
Pennsylvania Medical Society  
Rhode Island Medical Society  
South Carolina Medical Association  
South Dakota State Medical Association  
Texas Medical Association  
Utah Medical Association  
Vermont Medical Society  
Medical Society of Virginia  
Washington State Medical Association  
West Virginia State Medical Association  
Wisconsin Medical Society