

February 12, 2014

Kathleen Sebelius
Secretary
US Department of Health and Human Services
Hubert H Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Sebelius:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to you concerning ICD-10. Regardless of any informational reports or material posted on our website that discuss the feasibility of ICD-10 or ICD-11, AMA policy adopted by our House of Delegates calls for repealing ICD-10 for the simple reason that it is not expected to improve the care physicians provide their patients and, in fact, could disrupt efforts to transition to new delivery models. The transition to ICD-10 represents one of the largest technical, operational, and business implementation in the health care industry in the past several decades. Implementing ICD-10 requires physicians and their office staff to contend with 68,000 diagnosis codes—a five-fold increase from the approximately 13,000 diagnosis codes in use today. The broad use of ICD-10 codes for determining reimbursement, coding in all health care settings, and health care coverage has not been done in other countries, making the U.S. implementation unprecedented.

By itself, the implementation of ICD-10 is a massive undertaking. Yet, physicians are being asked to assume this burdensome requirement 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 interfering with their ability to care for patients and make investments to improve quality.

The AMA recognizes that our position on ICD-10 is at odds with many other well-intended stakeholders in the health care industry. We are not discounting the value ICD-10 data could have for research, public health surveillance, and other data analysis activities. Based on the concerns we articulate below, however, we question the logic of requiring physicians to adopt a new coding structure at this point in time.

ICD-10 is Financially Disastrous for Physicians

Many practicing physicians regard ICD-10 as a costly, unfunded mandate that will not improve patient care. Indeed, the cost to meet ICD-10 is much larger than originally estimated.

According to a new report by Nachimson Advisors, the estimated price for a small practice to meet ICD-10 requirements will range from \$56,639 to \$226,105. In comparison, the 2008 estimated cost for a small practice was approximately \$83,290. The previous estimate did not account for the costs to upgrade to certified electronic health record (EHR) software since Congress had not yet enacted the Meaningful Use Program. Therefore, many physicians are expected to have to spend considerably more to upgrade their software given the new regulatory environment.

ICD-10 Impedes Physician Progress to a Performance-based Environment

The AMA is committed to repealing the Medicare Sustainable Growth Rate (SGR) formula and helping physicians transition to innovative health care delivery and payment systems. Physicians' ability to purchase technology and participate in new payment and delivery reform models that improve care coordination and reduce costs will be stifled if their resources are diverted away in order to meet ICD-10. Many physicians are small business owners and, thus, their operating margins are already thin. Their ability to make capital investments will have to be put on hold as they contend with ICD-10. Since ICD-10 codes will be required for claims processing, physicians have no choice but to prioritize compliance with ICD-10 over other mandates and objectives. Given the significant cash flow interruptions stemming from previous Health Insurance Portability and Accountability Act (HIPAA) mandates, we expect the financial impact of ICD-10 on physicians will continue well beyond the October 1, 2014 implementation date.

Continuing to force physicians down the ICD-10 path will result in significant financial burdens for physicians. This impact will be compounded by their inability to devote time and resources to meeting other federal mandates that carry hefty financial penalties, which further threaten their financial viability. Physicians are facing serious financial obstacles from multiple sources including:

- Incurring costs to comply with the EHR Meaningful Use Program, which exceed available incentives;
- Purchasing EHR software certified for 2014 or a software upgrade that allows for use of ICD-10;
- Seeking upgrades from practice management system (PMS) vendors for ICD-10 software;
- Incurring financial penalties in the form of cuts to Part B reimbursement, including a 2 percent cut if Medicare ePrescribing is not met (cut taken in 2014), a 1 percent cut if Meaningful Use is not met (cut taken in 2015), and a 1.5 percent cut under the Physician Quality Reporting System (PQRS) (cut taken in 2015); and
- Mitigating a 2 percent cut stemming from Sequestration

The AMA recently collected data that shows that fewer than half (47 percent) of physicians queried say their practice management system (PMS) vendor plans on delivering them an ICD-

10 software upgrade. Of those who do expect an upgrade, 26 percent expect to receive it before April, 24 percent before July, 13 percent before October, and 1 percent after October. The remainder have not been notified when their software will be delivered. For those physicians using or expecting to use certified EHR software, vendors may be delivering upgrades for EHR and ICD-10 at different times, creating more complexity and disruption for physicians. Even if software upgrades were delivered by the end of the first quarter of 2014, that would leave only six months to meet Meaningful Use and ICD-10 requirements, an insufficient amount of time by our estimates to ensure the software is working as intended.

Medicare's Role in ICD-10

Testing

It is clear from a pilot test conducted by the Workgroup for Electronic Data Interchange (WEDI) and the Health Information Management and Systems Society (HIMSS) that testing is an important component to prepare for the implementation of a new code set. The pilot, which was conducted last summer using American Health Information Management Association (AHIMA) approved coders, saw only an average 63 percent accuracy for facility coders when using the new codes. While this pilot focused on the inpatient setting, it provides valuable insight into what lies ahead for the ambulatory setting where many small physician offices are unable to employ coders let alone certified coders.

The AMA is pleased that Medicare reversed its decision to conduct testing in advance of the compliance deadline. The type of testing Medicare is conducting, however, is not true end-to-end testing. While it will allow a physician to know whether his or her claim was received or not, it does not give any indication as to whether it will be paid, how much it will be paid, whether they have used the correct ICD-10 code, or whether Medicare believes more information is needed to adjudicate the claim. To draw a simple analogy, this is like receiving a package on your doorstep that you can only view from your window. While it is helpful to know the package has arrived, you have no idea what is inside until you are able to open it.

We would like to take this opportunity to again urge Medicare to conduct true end-to-end testing. If it is not possible to conduct this type of testing with all physicians, then we strongly urge Medicare to conduct true end-to-end testing with at least 100 different physician practices of varying sizes and specialties. Any experience gained through such a testing exercise should be used to inform Centers for Medicare & Medicaid Services' (CMS) decision to adhere to the October 1, 2014 deadline. We believe end-to-end testing is essential for ensuring the health care industry will not suffer massive disruptions in claims and payment processing and ultimately risk physicians' ability to care for their patients.

“Advance Payment” Policy and Medicare Free Billing Software

Our experience with HIPAA mandates is that there are always unforeseen obstacles. The AMA is concerned that Medicare is not seeking a more flexible advance payment policy, which will help ensure that cash flow interruptions do not threaten practice sustainability following the compliance date. To be clear, this is not a cash advance – it is payment for services already rendered by a physician that Medicare provides outside the normal reimbursement process.

Discussions with CMS staff indicate significant reservations around loosening the criteria a physician would need to meet to obtain an advance payment due to program integrity concerns and limited resources. We fully appreciate Medicare’s responsibility to protect the Trust Fund. We also understand the process for securing an advance payment is extremely manual for both Medicare and physicians. We would like to reemphasize that seeking an advance payment is usually a last resort option where a physician has already tried to resolve the matter at the contractor level without success and is now weeks or months away from receiving reimbursement. In most cases physicians in need of advance payment are facing dire financial hardship as a result of the nonpayment, which hurts their practice and jeopardizes their ability to treat Medicare patients.

While we understand that it would be challenging for Medicare to contend with numerous requests for advance payments, we only expect this process to be used for the most serious cases. We believe the change to ICD-10 will be equally challenging for physicians as the cash flow interruptions following the implementation of the National Provider Identifier (NPI) in 2008. Countless physicians were negatively impacted – many for more than a year – and Medicare enrollment was significantly disrupted by the transition to the NPI. These concerns were documented by *The Los Angeles Times* and required then Acting Administrator to issue the following statement:

It's not easy to acknowledge mistakes, but your article fairly points out that the CMS transition plan didn't work the way in which it was intended. We are aware of the issues and are in the process of solving the problem by updating provider enrollment records while at the same time ensuring the integrity of the Medicare program. First, we are making payments to eligible Medicare providers in financial distress by offering an advance against future billings.¹

Part of the challenge with the current policy is that Medicare will only consider an advanced payment if the claims have made it through to the contractor and the contractor can see them in its system. The reality is that many of the problems in the past occurred when the physicians’ claims were unable to get into the contractors’ systems. In such cases, the physicians have

¹ Untangling Medicare Pay <http://articles.latimes.com/2008/nov/12/opinion/le-wednesday12.S3> Nov. 12, 2008.

essentially submitted their claims, as required by the regulations, but are left at the mercy of others to get paid.

Medicare staff have suggested physicians hire consultants and use free Medicare Billing Software as a solution to address payment problems due to the transition to ICD-10. Hiring a consultant is not an option for many cash-strapped physicians, and, if the problem is on Medicare's end, there is no role for a consultant. We have conferred with physician billing and coding experts on the feasibility of using free billing software and, while it may be a viable solution for those whose software is not ready to handle ICD-10 codes, it will not address problems that originate with Medicare and the contractor's system. If the contractor or clearinghouse is having an issue on their end, it will not matter what software a physician is using.

It is our belief that only physicians in the most dire of financial situations should be eligible for an advance payment, keeping in mind that what constitutes dire for one physician may not be the same for the next. As small business owners, physicians simply are not in a position to have sustained cash flow interruptions, and it is in their best interest, as well as their patients, that these disruptions are minimized.

We recommend Medicare change their advance payment policy to take into account the following situations when a physician is in good standing with the Program:

- 1. When a physician has submitted claims but is having problems getting the claim to reach the contractor due to problems on the contractor's end;**
- 2. When a physician has not been paid for at least 90 days;**
- 3. When they attest that at least 25 percent of their patients are Medicare; and**
- 4. When they attest that at least 25 percent of their reimbursements are from Medicare.**

We believe that if these accommodations are made, it will help mitigate serious financial challenges to those physicians who are unable to get their claims processed. Our recommendation is consistent with one made by your own advisory committee, the National Committee on Vital and Health Statistics (NCVHS) that stated:

HHS should require Medicare to provide guidelines on advance payment policy during transition and other mechanisms to avoid disruption of services, and should require that Medicare set the example by publishing and readying such a policy.²

² Letter from NCVHS to the Secretary of Health and Human Services, <http://www.ncvhs.hhs.gov/110922lt1.pdf> Sept. 22, 2011.

Claims Attachments Use with ICD-10

The AMA has learned that CMS is not moving forward at this time with a regulation proposing an attachments standard and, instead, is waiting to align this regulation with that of the Stage 3 Meaningful Use regulations. We recognize that naming a single attachments standard is challenging in light of the evolving nature of how information is being exchanged. However, the requirement for a standard to be named originated in HIPAA in 1996, and the Affordable Care Act reiterated the mandate by calling for HHS to name a standard by January 1, 2014. This is one of the few standards with the potential to bring substantial cost savings directly to physicians. It is, therefore, incredibly disappointing that physicians will have to wait several more years before they can realize the benefits and the efficiencies that a standard transaction is expected to bring.

Medicare has stated in numerous public forums that the move to ICD-10 is expected to result in fewer requests for attachments and additional information to substantiate claims before physicians can be reimbursed. **We urge CMS to formally adopt a policy for Medicare that states when the most specific ICD-10 code is submitted by a physician no additional information will be required to adjudicate the claim, particularly in the absence of an attachment standard.**

Coding Requirements

The AMA has concerns about requirements that payers may put in place regarding the specificity of the ICD-10 code reported in claims. While we support that the diagnosis code should be as specific as possible to accurately reflect the patient's condition, there will be a period of time during the implementation of ICD-10 where physicians and coders are still gaining an understanding of the codes and how to use them. We are concerned that payers will place strict requirements on the specificity of the codes reported and reject or pend claims, further compounding payment disruptions for physicians.

We, therefore, recommend that CMS adopt a policy for Medicare that provides a two-year 'implementation' period during which Medicare will not be allowed to deny payment based on the specificity of the ICD-10 code, will provide feedback to the physician on any coding concerns, and will not be allowed to recoup payment due to a lack of ICD-10 specificity.

Conclusion

The AMA is committed to seeing physicians successfully transition to new payment and delivery reform models and adopt well-developed technology that promotes care coordination with real value to patients. Adopting ICD-10, while it may provide benefits to others in the health care system, is unlikely to improve the care physicians provide their patients and takes valuable resources away from implementing delivery reforms and health information technology. **The AMA strongly urges CMS to reconsider the ICD-10 mandate.**

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Should you have any questions, please contact Mari Savickis, Assistant Director, Federal Affairs, at (202) 789-7414 or mari.savickis@ama-assn.org.

Sincerely,

James L. Madara, MD