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Testimony of the

American Hospital Association

before the

National Committee on Vital and Health Statistics'

Subcommittee on Standards

Hearing on HIPAA and ACA Administrative Simplification:

Operating Rules, ICD-10, Health Plan ID, Pharmacy Prior Authorization

Wednesday, February 19, 2014

Good morning, distinguished members of the National Committee on Vital and Health Statistics' (NCVHS) Subcommittee on Standards. I am George Arges, senior director of the health data management group at the American Hospital Association (AHA). On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the AHA appreciates the opportunity to testify regarding the transition to ICD-10.

PREPARING FOR ICD-10

The AHA has supported the transition to ICD-10 because it provides needed modernization of coding and billing systems. ICD-10 will allow for greater coding accuracy and specificity, and will provide a mechanism to capture and fully describe new medical technologies and advances. More detailed coding systems also will improve our nation's understanding of the diseases or illnesses being treated and will provide caregivers and the public with better information on future treatment.

For the past three years, our member hospitals have been preparing for ICD-10. It has involved careful planning and coordination of a wide range of hospital resources that span many departments and a variety of hospital personnel, including medical staff and clinicians. For hospitals, this transformative change initiative involves organizing, planning and implementation. The AHA has encouraged hospital leaders to make certain that their hospital has adequate resources in place to ensure a successful transition to ICD-10 and urged hospital leaders to closely monitor the transition's progress.

Based on preliminary data from an AHA survey that concluded last week, we found that the vast majority of hospitals are confident that they will be ready to transition to ICD-10 by the Oct. 1 implementation date. Most are actively training coders, educating clinicians, and either beginning or planning for testing with payers. These preliminary results are consistent with the findings from a survey of 775 hospitals that we conducted last Spring. (The issue brief on this survey is enclosed.) The AHA soon will publish a summary of the most recent survey findings, and we have a number of educational resources planned that will help hospital leaders navigate the remaining steps as they transition to ICD-10.

IMPLEMENTATION AND TESTING

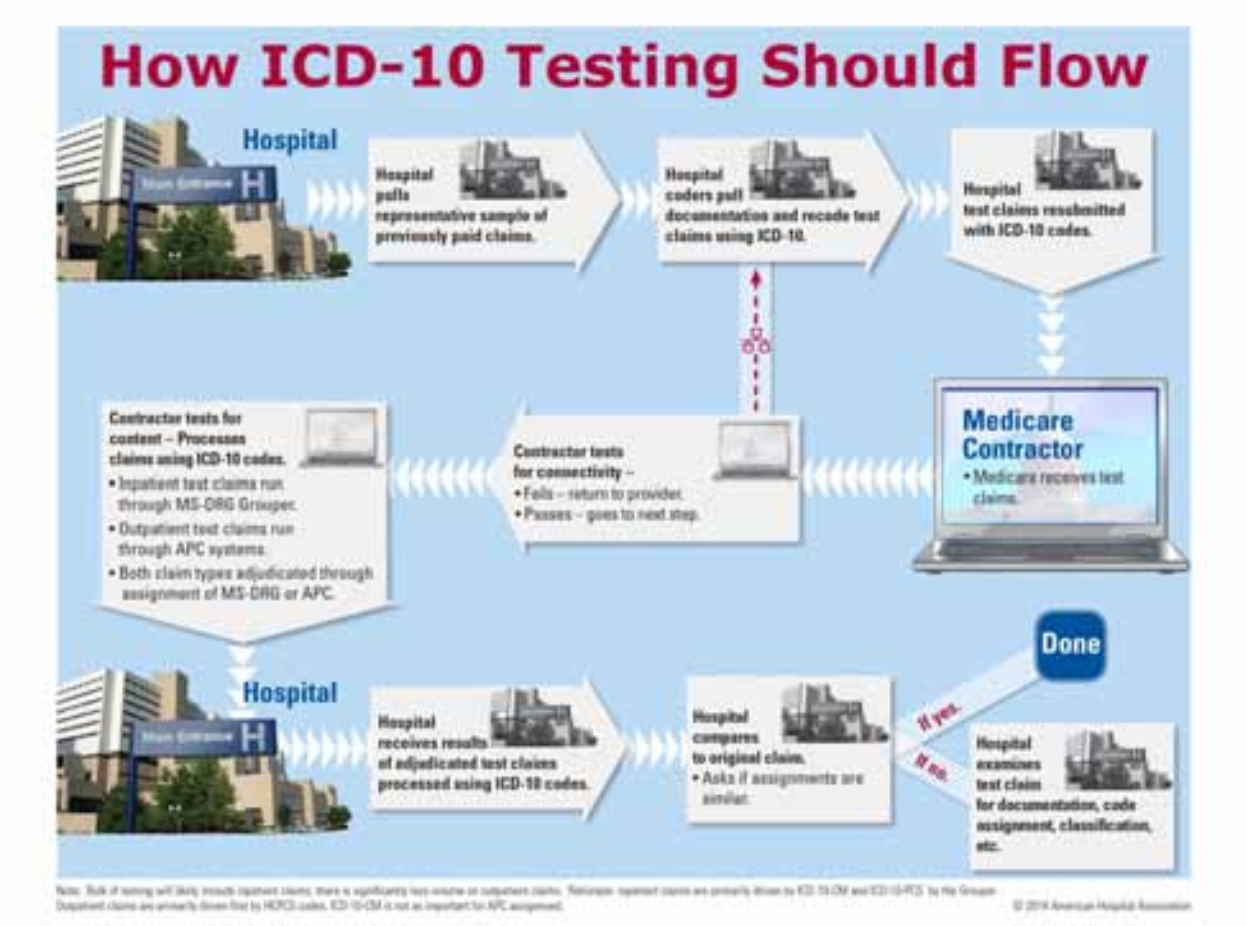
The focus of the transition to ICD-10 should now be on the implementation phase. This phase includes completing coding staff training, finalizing information system changes, conducting financial impact assessments, completing internal testing, and contacting payers, clearinghouses, and other trading partners to schedule testing. The staff training and finalization of system changes include fine-tuning the processes for ICD-10 code assignment, identifying strategies to offset the negative impact associated with the expected decrease in productivity and claims submission as coders learn how to use ICD-10 routinely, and educating physicians about ICD-10 coding concepts and the importance of improving documentation.

A key component of implementing ICD-10 will be testing. Last November, AHA sent a letter to the Centers for Medicare & Medicaid Services (CMS) urging the agency to expedite its ICD-10 testing plans to ensure that testing begins no later than January 2014 and be made available to all hospitals. While we appreciate the agency's efforts to offer many educational opportunities for providers, extensive, end-to-end testing by Medicare contractors and state Medicaid agencies of both the electronic transaction and the adjudication of the claim will be needed to ensure a smooth transition from ICD-9 to ICD-10. Indeed, the implementation timelines on CMS's ICD-10 Web page (http://www.cms.gov/Medicare/Coding/ICD10/ICD-10ImplementationTimelines.html) show that testing for hospitals should have started in October 2013, and continue through this summer.

We continue to receive calls from member hospitals who have indicated that they are ready to test with CMS, and preliminary results from our recent survey indicate that most hospitals identified lack of timely testing with Medicare and Medicaid as posing a risk to meeting the Oct. 1 deadline. Therefore, we are very concerned about a recent CMS notice that identified only one week in March for ICD-10 testing.

Testing only one week in March is not adequate. We urge CMS to expedite the testing process to begin as soon as possible and ensure all testing is complete by the end of June so that providers, payers and clearinghouses can resolve any issues discovered during testing and complete training well in advance of the Oct. 1 transition date.

Based on discussions with member hospitals, we have learned about the key components that should be part of a testing process. We have designed a graphic, which appears below, to show how the testing should flow. While this graphic is specific to Medicare, it also applies to private payers and Medicaid. The graphic illustrates two key components that should be part of ICD-10 testing – testing for connectivity and for content.



The initial testing approach that many hospitals are using consists of selecting a representative sample of previously paid claims and recoding them to ICD-10. If the claim passes the front-end edit, it is then ready for the content evaluation. In this step, the health plan will typically examine the diagnosis and procedure codes along with other pertinent information on the claim to determine how it would adjudicate the claim for payment purposes. For inpatient hospital claims that are paid under a diagnosis-related group (DRG), payment would be based on the DRG assigned using ICD-10 codes. Hospitals should be able to compare the DRG assigned using ICD-10 to the DRG assignment on the original claim. If the two DRG assignments are

consistent, then the hospital can feel confident that the coders have appropriately interpreted the medical record and used the right ICD-10 code. If not, the hospital must investigate the cause of the discrepancy. This process includes examining whether the documentation used to assign the ICD-10 codes was complete, whether coding staff assigned the correct ICD-10 code from the documentation, or whether some other factor, such as a change in the structure of the DRGs, caused the DRG assignment to be different than it was under ICD-09.

For outpatient hospital claims a similar testing model should be conducted recognizing that content review for outpatient claims is primarily driven from the Healthcare Common Procedure Coding System (HCPCS) codes assigned. Since the use of HCPCS is a continuation of the existing HCPCS codes currently reported on outpatient claims, we expect that a smaller number of outpatient claims will be tested.

It is true that under ICD-10, the coding system will grow significantly. However, this expansion is based on reasons such as the identification of laterality (i.e., left, right or bilateral), creation of combination codes and identification of chronology of encounters for injuries (e.g., initial, subsequent or sequelae). Although the code set is large, any physician practice would use only a small subset that is relevant to the services it delivers. And, specialty societies have developed many tools to facilitate the transition, such as developing "Top 50" lists by specialty. Surgeons and others performing surgical procedures will be exposed to both new diagnosis and procedure codes.

Physicians will need to learn about ICD-10 and ensure that they have provided sufficient documentation for coders to select the correct codes. Most physicians will not be responsible for knowing the actual codes, however, and will need to learn about only conceptual changes to the subset of codes specific to their clinical area. Professional coders hired by hospitals will be responsible for assigning ICD-10 codes. Physicians will need to be sure to include laterality in notes and may be asked to describe the patient's diagnosis with more detail than previously documented to differentiate. For example, coronary artery disease includes combination codes for without angina and with angina, with unstable angina, with documented spasm, or, with unspecified angina pectoris. That level of detail, while entailing some learning, is helpful to evaluate care and share more specific information with other caregivers about the patient's condition.

Between now and the end of June, the focus should be on testing both connectivity and content of claims using ICD-10 codes. The lessons learned from this testing period will allow providers and health plans the opportunity to evaluate whether additional adjustments or improvements are needed, and it would give them enough time to make any necessary adjustments.

Other implementation steps include completing training for clinical coding staff. During this period, hospitals also will start dual coding in order to help coders become more familiar with using ICD-10 codes. At the same time, hospitals anticipate that the move to ICD-10 will affect coding productivity and could negatively impact the hospital's revenue cycle.

CONCLUSION

The move to ICD-10 is important to ensure payment accuracy and build our understanding of health care delivery. A successful transition requires cooperation from all parties – health care providers, public and private payers and clearinghouses. As the clock runs out on preparation time, all parties must re-double their efforts to ensure a smooth and timely roll-out of the project.

Thank you for the opportunity to participate in this panel discussion, and we look forward to working with NCVHS and others to achieve a successful transition to ICD-10. Should you have any additional questions or concerns please contact me at garges@aha.org or (312) 422-3398.

Enclosure