Testimony of

The Healthcare Billing and Management Association

ICD-10 CM Planning, Testing, Preparing for Implementation

Before

The National Committee on Vital and Health Statistics (NCVHS)
Subcommittee on Standards

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Presented By

Holly Louie, RN
Chair
HBMA ICD-10 Committee

Mr. Chairman, and members of the National Committee on Vital and Health Statistics Subcommittee on Standards (NCVHS). My name is Holly Louie and I am the chair of the ICD-10 CM Committee of the Healthcare Billing and Management Association (HBMA). I want to thank you for this opportunity to again give you our perspective on the current status of the ICD-10 CM coding system implementation.

The Healthcare Billing & Management Association (HBMA.org) is a key stakeholder in the $38 billion physician Revenue Cycle Management industry. We have over 700 members and more than 500 companies that employ more than 30,000 individuals at billing and revenue cycle practice management firms. We estimate that annually, HBMA member companies submit more than 350 million initial claims on behalf of physicians and other healthcare providers.

In addition, HBMA members frequently perform all of the physician's practice management functions, accounts receivable management, medical billing consulting, as well as assistance in the preparation and completion of provider enrollment forms and other administrative and practice management services. Our member companies work with virtually every medical specialty and subspecialty and are knowledgeable, high-volume users of nearly every commercial billing product on the market. In addition, many HBMA members provide coding services in addition to billing – our member companies employ thousands of professional coders, many of who are expert in their respective clinical specialties. We believe HBMA is uniquely positioned to comment on the ICD-10 CM questions of concern to this committee.

HBMA has been providing education to assist our members and their clients prepare for ICD-10 CM implementation since 2009. We are well aware that this is not simply a coding change, it is changing the payment model and therefore has the potential to be extremely disruptive to the entire universe of healthcare.

When we testified before this Committee in both 2012 and 2013, we stressed the important lessons learned from the difficult transition to 5010 the stakeholder community experienced in 2012. As we sit here today, it does not appear that we learned those lessons. Our comments today reflect that reality.

Although disappointing to many, the recent action delaying ICD-10 CM for another year provides us with a golden opportunity to do the work to avoid a recurrence of these problems. We have the opportunity, over the next 18 months, to robustly test all of the documentation, coding methodologies, practice management systems, interfaces and adjudication systems affected by this change. In other words, we can have 18 months of end-to-end testing.

Unfortunately, the extremely disappointing response from CMS that they would delay this necessary testing until 2015 completely squanders that opportunity. Following CMS' lead, some commercial payors have already announced that they will delay robust testing with trading partners, which should be well underway, until the summer of 2015. It certainly begs the question: Were all who represented they were ready for the October 1, 2014 changeover, truly ready?

We believe this is a critically important point. An HBMA member survey conducted in May of this year found only a very small number had conducted any full end-to-end testing. Of the testing that was possible, which included the Medicare contractor high-level syntax-only testing in March, 38% reported it was unsuccessful. That is a very different finding than the CMS notice published on May 30 that stated contractors accepted 89% of the test claims and therefore testing was successful.

Our survey also found that full end-to-end testing and payor cooperation tied for the second biggest impediment to ICD-10 CM readiness. We cannot stress strongly enough that syntax only testing is not adequate. Failure to engage in end-to-end testing will result in significant problems at the time of implementation because adjudication systems were not tested. We believe our survey offers strong evidence that stakeholders are not ready to implement ICD-10 CM and much work remains to be accomplished.

HBMA strongly recommends national testing schedules beginning **now** and continuing through September, 2015. Testing must accurately represent a live claim environment and **must** include the adjudication and 835 response. Furthermore, all local and national coverage decisions that will be active on October 1, 2015 should be published and available as future policies.

We also urge NCVHS to recommend a Local Coverage Decision (LCD) freeze through April, 2016. This will allow for end-to-end testing in an environment that fully replicates the adjudication environment that will exist when the changeover occurs. If providers are going to have confidence that their claims are going to adjudicate properly under ICD-10 CM – meaning that the claim gets paid at a level comparable to what would have been paid under ICD-9 CM – then it is imperative that the testing environment approximate the live environment as closely as possible. This makes it critical that there be an LCD freeze similar to the Code Set freeze that was instituted last year for new codes.

End-to-end testing that includes test claim adjudication cannot be avoided, circumvented, or severely limited if there is to be any possibility of a smooth ICD-10 CM implementation. It is also critically important to ensuring that providers believe that there will be no disruptions in payment because for the provider, the critical issue is, "Will I get paid?"

We believe an equally important problem now facing the industry is that the announced decisions delaying testing until 2015 is being perceived as evidence that ICD-10 CM is not going to happen.

The original one-year delay – from Oct. 1, 2013, to Oct. 1, 2014 – announced by Secretary Sebelius on Aug. 24, 2012 when viewed in conjunction with this new delay, has undermined the credibility of every one of us when we try to work with trading partners, stakeholders and, most importantly, our providers.

While some stakeholders will continue on course, many have either significantly slowed the work remaining or stopped all work on ICD-10 CM until they are confident it will be money well spent.

There is no doubt there are costs associated with the delay. Retraining, rehiring, reeducation, restaffing, reallocation of resources, reprogramming, etc. have added unavoidable costs with no ROI. Despite what the Congressional Budget Office said when they opined on the cost of delaying ICD-10 CM for an additional year, delaying will cost millions of dollars – if not billions of dollars. It would be wonderful if everything could continue on the implementation schedule as planned, but that is not realistic for many, given the current pressing needs for our businesses and client practices.

It seems the lessons learned and testified to by many before this committee over the past three years have not resulted in corrective actions or demonstrated plans to address the issues of concern. If anything, those same concerns were again proven to be true with the less than hoped for roll out of the Exchanges and subsequent capabilities to remediate identified problems. I would like to remind the Committee of a few key points from our previous testimony and how they relate to where we are today.

5010 LESSONS – WHY HAVEN'T WE LEARNED FROM THAT EXPERIENCE?

The 5010 Transition in 2012 was subjected to what seemed to be an active and dedicated effort to plan and monitor the transition. There appeared to be an unprecedented level of education and efforts by stakeholders to share information and resources, with the goal of a successful transition. Despite this, there were serious problems with the 5010 transition.

In our view, central among the shortcomings in the 5010 transition was the lack of a standard definition of what it meant to be "5010 ready." What we subsequently learned was that every entity in the claims processing chain had a different definition of what they meant by the term "ready."

We also learned from the 5010 conversion that payor testing was severely limited. Many payors only tested syntax prior to the implementation of 5010 and in many cases the scope of testing did not adequately cover the true edits nor did the testing provide for end-to-end testing with full claim level adjudication and remittances as part of the test. In addition, no time was planned for remediation and retesting before final implementation.

We do not believe allowing payors to implement and process both ICD-9 CM and ICD-10 CM claims in the interim is an acceptable option.

One of the lessons learned with 5010 was that allowing payors to set idiosyncratic implementation schedules created bigger and more complex problems.

In addition, even more time, expense and work would be required to code every claim based on payor specific policies.

Remember, one of the goals of the ICD-10 CM initiative is administrative simplification – not administrative complication. Programming for a claim by claim basis to meet the requirement of each payor as they implemented ICD-10 CM on unpredictable schedules is simply not a reasonable solution. The best solution is the one the industry stakeholders have strongly recommended – end-to-end testing.

Therefore, in the time remaining before full implementation of ICD-10 CM, we ask this Committee to encourage both CMS and the Secretary to establish periodic benchmarks that cannot be ignored to assess the status for all facets of the healthcare industry. We were very concerned when CMS announced that they were waiting until mid-summer 2014 to engage in ICD-10 CM end-to-end testing, it was going to be too late for October implementation. Similarly, if there is to be full, robust end-to-end testing with follow-up opportunities for remediation, then it must start NOW, not a year from now.

"ICD-10 CM ready" should mean, at a minimum, that complete end-to-end testing of 837 and 835 transactions in full production was successfully accomplished. Given the diversity in possible maps, crosswalks, or translations from ICD-9 CM to ICD-10 CM – from GEMS to proprietary programs – transparency in the tools used is also imperative.

HBMA recommended Health Plan coverage policies be published by October 1, 2013. However, we were willing to accept the promised LCD publication in April 2014. This would allow adequate time for education and training, programming, data analysis and other preparations necessary for provider/practice specific ICD-10 CM impact that cannot be completed without that information. Consistent with our previous recommendations, we request that all national and local coverage determinations be published as future policies no later than October 1, 2014.

A full year of true end-to-end testing should allow adequate testing with major trading partners. We understand that it will be both impossible and unreasonable to attempt to test with every possible trading partner. **However, failure to test or limiting testing to only a few organizations, providers, specialties, or entities at the eleventh hour will surely result in significant failures and problems**.

We cannot stress strongly enough that failure to engage in meaningful end-to-end testing with adequate time for remediation is absolutely critical. If the current HBMA survey data accurately reflects the current environment, and end-to-end testing is not conducted, we can expect a significant percentage of claims will be negatively impacted when ICD-10 CM commences. That would represents millions of claims and tens of millions of dollars in payments. We believe it is unacceptable to wait until the last minute to know whether the issues and problems identified by testing can be corrected by October 1, 2015.

PHYSICIAN ISSUES REMAIN UNRESOLVED

Numerous surveys and reports by various organizations found, and continue to find, that greater than 40 to 50 percent of physician documentation cannot be coded to the most specific codes currently available in ICD-9 CM. HBMA also understands that many, perhaps most, diagnosis codes reported for non-facility physician professional services are not the most specific ICD-9 CM option as a direct result of the suboptimal documentation.

We believe the focus on clinical documentation is a very relevant and critical issue for patient care that has been lost in the push for more specific codes to report the services provided. Coding is contingent upon the accuracy and adequacy of documentation. Excellent clinical documentation for ICD-9 CM will also likely be excellent documentation for ICD-10 CM, just as inadequate documentation for coding now will still be inadequate under ICD-10 CM. Physicians care about what the medical record says far more that what numeric descriptor is used to report the care.

Part of the rationale for moving from ICD-9 CM to ICD-10 CM is the greater degree of diagnostic specificity and clinical granularity of ICD-10 CM. Similar to ICD-9 CM, the ICD-10 CM codes

also include unspecified coding options. If there is no requirement to accurately document and report the most specific codes for each patient encounter, the improved data analytics and outcomes projected as a result of ICD-10 CM utilization will never materialize.

If unspecified diagnoses will continue to be paid as they are today, then why are we going to the work and expense to change coding systems?

We believe the focus on specificity has been lost in the ridiculous. The, "There's a code for that" type scenarios published in numerous media and venues that focuses on being bitten by turtles, catching fire while waterskiing, or being hit by a meteor in a double wide have been successful in making many think ICD-10 CM is ludicrous, not necessary. I believe these issues are accurately reflected in the HBMA survey where 60% of the reporting companies found physicians to be the biggest impediment to readiness. More importantly, our members reported that 75% of their clients supported delaying ICD-10 CM. Many members are reporting physician clients do not want to have any discussion about ICD-10 CM until such time as implementation it is an absolute certainty. We – all of us – have a credibility problem with the provider community due to our assurances to them in 2012, 2013 and early this year that there would be no delay. This has made reengaging them extremely difficult.

Substantive changes in our approach must occur or physician buy-in will be lacking as much or more in 2015 as it is today. This is not a simple problem solved by more education.

Why can't we give providers specifics about coverage policies, documentation requirements, adjudication determinations and possible reasons for payment disruptions based on true and meaningful end-to-end testing?

A BIG vs. SMALL PROBLEM IS NOT RESOLVED

A recurrent concern has been the time, money, staff expertise, practice disruption and resources required to implement ICD-10 CM and the disparity between larger organizations and small ones. Certainly some small organization and practices may be well ahead, and some large organizations

and practices may be lagging. However, it appears we have a chasm that remains unresolved and inadequately addressed. At a recent WEDI meeting, it was reported that smaller physician practices spent significant money on implementing a government certified electronic medical record product that does not work as promised so a replacement is required.

Because it was a certified product, credibility and distrust in "government" programs is an issue of concern. In addition, we heard that cash reserves are very low, they do not employ and cannot afford professional coders, the promised ease of a superbill does not fit their practice, and ICD-10 CM preparation is a significant practice disruption. These problems are compounded when change results in additional time away from patients because that is a negative impact on cash flow. When we consider the prevalence of extremely high patient deductibles that require payment plans, grace period for exchange patients, and implementation of other regulatory requirements, the resources are simply not there.

HBMA SURVEY MAY 2014

These findings appear to be mirrored in the HBMA survey. Although responses included large companies with well over 100 employees and mid-sized companies with 25-99 employees, 52% of the responses were from companies with less than 25 employees. The responses included companies providing services to office based, hospital based and other types of specialties, such as ambulance, DME, etc. in multiple states. 49% use computer assisted coding applications and 51% do not. Coding is performed by the billing company and clients, as well as outsourced.

- 58% provide services to office based physicians.
- 43% of diagnosis coding is performed by the client.
- Largely because their clients were not ready and/or they have not been able to test, 41% of billing companies reported that they would not have been able to submit an ICD-10 CM ready claim on October 1, 2014.

Although CMS, through the NGS industry stakeholder project, developed many excellent tools for small providers, and has additionally provided numerous tools, information and guides for small

providers, they have not resulted in widespread small practice readiness. Continuing on the same path for the next year will not result in a positive change for this group of small stakeholders who are struggling due to lack of resources. What can we do to help these practices, organizations and companies?

CONCLUSION AND RECOMMENDATIONS

On behalf of the Healthcare Billing and Management Association, we appreciate your consideration of these comments.

RECOMMENDATIONS:

1. The industry needs help from CMS to overcome the credibility issues resulting from the delay. We need certainty – or as much certainty as can be provided – that the October 1, 2015 date is real.

2. Payor coverage policies should be published NOW and then frozen through March, 2016.

3. If we do not use the additional year to establish realistic and enforceable interim milestones for ICD-10 CM conversion, starting NOW, we will find the additional time was wasted and we will be in exactly the same place next June.

4. End-to-end testing, using the agreed upon NGS project definition, should continue and not be delayed for another year. Limited or no end-to-end testing will surely lead to failures. Syntax only testing is not an acceptable methodology for determining readiness or predicting claims and payment disruptions. Syntax only testing is simply a milestone marker along the way. Equally important: one or two months to remediate the problems identified by end-to-end testing is not realistic or adequate.

5. Because the CMS Medicare contractors were to publish LCDs in April, 2014, there is no compelling argument against doing so to aid the provider community in preparations. The

policies should be used for adjudication in end-to-end testing. Known coverage policies are required to complete the work of implementation and to assist physicians in improving documentation and to allow software vendors to incorporate them into sophisticated products.

6. We urge you to recommend that CMS consider the industry impact of their policy decision on external testing and the delay until an unknown date in 2015. Not only for all the reasons articulated above, but because commercial plans are following that lead in delaying testing and publication of policies, in some cases until mid-summer 2015.

7. We also respectfully ask CMS to consider whether HBMA and other organizations will be excited about and willing to collaborate, contribute volunteers, and dedicate time and resources to future CMS outreach efforts if CMS rejects the recommendations of the industry experts from whom they sought help.

8. We recommend CMS convene an industry stakeholder group of representatives from small providers, entities, organizations and companies immediately. We can no longer afford to ignore the problems this group has in achieving readiness or assume they have the tools and resources to proceed. All the additional education alone will not solve the problems. Financial support, similar to that provided for implementation of electronic records, should be strongly considered.

Two years ago and again last year at this meeting, the industry collectively said, “We told you so.” Please don’t let that be the message again next year.

“Those who cannot remember the past are condemned to repeat it.” George Santayana