Testimony of

The Healthcare Billing and Management Association

ICD-10 Planning, Testing, Preparing for Implementation

Before

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

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Presented By

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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 implementation of the ICD-10 CM coding system.

The Healthcare Billing & Management Association (HBMA.org) is a key stakeholder in the $38 billion physician Revenue Cycle Management industry. Our member companies employ more than 30,000 individuals at well over 700 third-party medical billing firms. Annually, HBMA companies submit more than 350 million initial claims on behalf of hospital-based physicians, office-based physicians and other allied healthcare providers. HBMA member companies process over 30% of all physicians' insurance claims.

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. 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 in preparing 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 last testified before this committee one year ago, we stressed the important lessons learned with the 5010 transition. We believe our comments today still form the foundation of the current state of ICD-10 CM readiness. Given the recent shocking transmittal from CMS to its contractors that true end-to-end testing with external trading partners need not occur, I would like to remind the committee of the key points from our previous testimony.

5010 LESSONS – WILL WE LEARN FROM THAT EXPERIENCE?

The 5010 Transition 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 have 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, we learned that:

> Planning could have been more in-depth with more stakeholders more intimately involved;
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> Communication could have been clearer, more comprehensive and more broadly disseminated; and,
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> No time was planned for remediation and retesting before final implementation.

The lack of transparency made it virtually impossible to know where problems were, i.e. one clearinghouse handed off to another and the provider/billing company only knew they had no issue with step one in the chain so they could not determine why the claims were denying because they did not know about steps 2 and 3.

As you know, ICD-10 CM has far more impact and involves far more changes than 5010. Unlike 5010, physicians must be personally and actively involved in the ICD-10 CM process. We are concerned that unless the lessons learned from 5010 materially inform and affect the implementation of ICD-10 CM, the economic stability of America's healthcare reimbursement systems will be at risk and could be severely compromised.

Prior to the recent transmittal mentioned above, we believed CMS shared the industry concerns and was actively involved in planning for a successful transition. Initiatives such as the National Government Services (NGS) Industry Collaborative Partners (ICP) are excellent opportunities to design effective implementation processes. We do not understand why CMS would essentially undermine and negate the months of very hard work, time, and effort involved in the NGS project (a CMS OESS initiative) – a project designed specifically to avoid the known threats to successful ICD-10 CM implementation.

It is difficult to imagine, or even articulate, the magnitude of changes required for ICD-10 CM implementation. Every vendor system that stores, uses, depends on, transmits, or receives an ICD code, for whatever purpose, must make some degree of modification to some component of the software to accommodate ICD-10 CM. In the process, each vendor is forced to make decisions and set rule(s) or policies regarding how they will treat ICD-10 CM codes and handle the transition from ICD-9 CM to ICD-10 CM. We are well aware that with little more than a year remaining before the effective date, an enormous amount of work remains to be done.

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.

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

HBMA recommends Health Plan coverage policies be published by October 1, 2013. This would allow adequate time for education and training, programming, data analysis and other preparations necessary for provider/practice specific ICD-10 CM impact.

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 will surely result in significant failures and problems**.

We cannot stress strongly enough that failure to engage in meaningful end-to-end testing is a recipe for disaster.

In addition, the testing should provide for a full weeks' worth of de-identified production claims processed in a test harness. This will ensure all possible test scenarios are accounted for, a lesson from 5010 we should heed.

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 reported 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.

Similar to ICD-9 CM, the ICD-10 CM codes include unspecified reporting options. 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. 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 that is to be the end result, why are we doing this?

More importantly, as we look at what we know in the summer of 2013, payor policies are so divergent that additional confusion is the result. For example, some payors have not yet provided any information regarding coding requirements for payment. A few payors (Kansas BlueCross BlueShield, for example) have published that no unlisted or not otherwise classified codes will be accepted. In other cases, it appears it will be business as usual. One of the oddest payor responses was from a commercial BlueShield plan that advised if a provider wanted to know what their coverage criteria will be to, "ask AMA or CMS." It is unclear to our members and our clients how such variance in the coding requirements to meet medically necessary coverage policies will result in the quality of data intended, or what will be useable for any comparison purposes. Perhaps more importantly, how can the same documentation represent quality care to one payor but not to another?

Ask any physician and they will tell you they provide good care. Many do not comprehend how documenting a few more words can be used to assess quality, medical necessity, patient outcomes or any other clinical parameter. To quote one physician, "Do you mean to tell me if a physician provides horrible care but includes all the words that means his quality is better than mine?" As an industry, we have not done a good job of speaking their language and connecting true quality care with excellent documentation.

This Committee, CMS and HHS all need to understand that for most physicians the bottom line question is, "Will I get paid?"

With so little time remaining, how can we possibly tell them we do not know and expect them to embrace this change? Why can't we give them specifics about coverage policies, documentation requirements, and payment disruptions?

We believe a major factor in physicians' hesitation about undertaking the steps necessary to meet the ICD-10 CM deadline can be placed at the government's doorstep.

Historically, CMS ICD-10 CM education has stated that physician practice changes are not needed or are very minimal. The narrative often indicates that the physician can "just update a

superbill with your top 30 codes." Although they are told they can look up any other codes, that message got lost. Finally, the message often concludes with reassurances about the availability of "unspecified" codes. We believe this contributes significantly to lack of focus on preparation for ICD-10 CM (see attached examples).

Finally, we are aware that various maps and crosswalks are believed to be the magic bullet to solve the challenges involved in implementing ICD-10 CM. Likewise, many vendors are marketing, and physicians believe an EHR or EMR – AKA the Electronic Magic Record - that assigns codes will solve any and all issues in correctly coding ICD-10 CM.

The critical point that is omitted from the vast majority of conversations specific to this topic is that these are tools, not coding! One of the major payors summarized this issue very well. Because there are fundamental differences in language and codes, attempting to use a crosswalk or map as a work-around to learning and accurately reporting ICD-10 CM codes will result in catastrophic failure. It should be very clear that maps, crosswalks, and EHR are not a viable coding solution.

ARE POST OCTOBER 1, 2014 PROBLEMS INEVITABLE?

What has changed during the past year? Will the implementation delay to 2014 enable the industry to achieve the readiness goals? Are we missing critical pieces or milestones? What are the critical steps we need to take in the remaining time to minimize problems? While progress has been made and will continue through the next year, resolution of the more fundamental questions appears to be lagging.

1. WHAT PAYORS AND TRADING PARTNERS ARE "READY"?

The NGS ICP workgroup has an established definition of ready that we believe **every** entity and trading partner should be required to use. Consistency in correctly using the term "ready" should eliminate the divergent meanings and resulting confusion and problems experienced with 5010. Unfortunately, we have not seen widespread industry acceptance of the definition to date. If the

published ICP definition is not used by a vendor, payor, plan, entity, or other trading partner, any idiosyncratic definitions should be published.

2. END-TO-END TESTING

HBMA understands that it will not be possible to test with every possible payor, vendor and trading partner. However, the ability to complete end-to-end testing between critical partners is imperative to avoid problems, payment delays and industry disruptions. Perhaps the most important lesson learned from 5010, and other initiatives, was that testing was too little, too late, too superficial and too lacking in transparency. No time for corrective actions and/or remediation was built into the process.

Because ICD-10 CM is exponentially more difficult than 5010 and because it is all about payment, not simply transaction format/syntax, this is shortsighted and almost certainly headed for failure. We must remember that 5010 was the "same" for all HIPAA transactions and yet major problems occurred. ICD-10 CM is used for payment determination by every payor so there are literally thousands of different outcomes for the same code due to not just systems, but code maps and crosswalks, coverage determinations, risk analysis and payment policies.

The CMS transmittal referenced above and subsequent announcement by some payors that they will not test with trading partners, but rather test internally only and/or with a few major partners or types of providers is extremely concerning. It is also in direct conflict with the historical ICD-10-CM publications on the CMS website. The sheer audacity that providers should trust a representation that they can successfully adjudicate live claims is unconscionable and certainly not based on well-known facts from 5010. Part A, Part B, ambulance, and DME claims will all use diagnosis codes, but the specific criteria, clinical context, claim information, and other parameters can vary widely.

For example, testing Part A claims would tell you exactly nothing about Part B claims. We have heard anecdotally that some payors are already engaging in some forms of testing and others have no testing dates scheduled. A recent HBMA survey indicated zero members, or their vendor partners, are currently able to test with any payor. We are very concerned that the CMS

testing position will permeate the commercial payors and ultimately severely restrict or eliminate meaningful industry wide end-to-end testing. After all, why should commercial payors go to the expense of testing if the government says, in effect, testing is not necessary.

Should that prove true, we predict there will be significant payment disruptions to providers at large, well above the previously cited potential of two years. Frankly, we can only imagine how such a disruption will negatively impact patient access and potentially provider survival.

HBMA strongly recommends national testing schedules beginning now and continuing through 2014. Testing must accurately represent a live claim environment and **must** include the adjudication and 835 response. The coverage policies that will be in effect on October 1, 2014 must be used in the testing process. End-to-end testing absolutely cannot be avoided, circumvented, or severely limited if there is to be any possibility of a smooth ICD-10 CM implementation.

3. COVERAGE POLICIES

Billing companies, coders, providers and practice managers need to know what changes to expect in coverage policies. Everyone involved in medical record documentation of services, reevaluating EHRs, training professional coders, choosing or modifying coding tools, designating the most accurate diagnosis code(s) and planning for the coding transition needs to know what various payor policies will be.

This is not a new concept and it is not an attempt to circumvent the system or ask for inappropriate payment. It is the simple fact that different payors have different criteria for payment, regardless of the coding system. In depth knowledge of the criteria each payor defines as representative of medical necessity is an important element of education and training. When a real coverage policy for advanced diagnostic imaging allows payment for shortness of breath but not for difficulty breathing, a fact that makes no sense to any physician, understanding the new terminology specificity is a necessary preparation step.

The current wide disparity in ICD-10 CM policy statements to date further exemplifies this conundrum. As explained above, the fact that some payors have published that they will not accept or process unspecified and/or not otherwise classified codes and others have publicly stated they plan no substantive coverage changes at this time means there are extremes. A successful implementation cannot be based on the extreme outliers.

4. THE PROBLEM WITH DISTRACTIONS

In emergency medicine, the term "distracting injury" means the patient has some very visible and attention grabbing injury, for example a fracture of the lower leg with the bone sticking out or an amputation of some fingers. If the medical team focuses immediately on the obvious, they can miss the less visible but lethal injury, such as internal bleeding, that will kill the patient. We believe successful ICD-10 CM implementation is compromised by the equivalent of distracting injuries.

- The new CMS policy instruction to contractors regarding testing will likely disrupt planning. Investing time, money, attention, and effort into developing effective readiness checklists is rendered meaningless if you have no way to use or validate them externally through end-to-end testing. More importantly, there is no possibility of correcting or remediating problems, a critical step for success. As a result, resources will be held for contingencies and problem solving based on the assumption the anticipated implementation failures occur.

- Repeated public pronouncements by influential individuals and/or organizations to stop the transition to ICD-10 CM leads some to conclude that waiting is the wisest course of action and distracts providers from focusing on preparations.

- Ridiculing ICD-10 CM codes such as "burn due to water-skis on fire, subsequent encounter." Does it sound silly? Yes. Will you ever need to code it? Doubtful. Drawing attention to a few extremely odd code examples misleads the less knowledgeable provider into believing all ICD-1O CM is equally preposterous and

unnecessary. Those examples distract providers from focusing on the specificity that matters in their practice and to their patients.

· Promises of miracle cures. There is no vendor, EHR, coding assist tool, map, crosswalk or other product that will solve the problem of excellent medical record documentation and accurate coding. Marketing impossible solutions to real problems distracts providers from the necessary analysis of where they are, where they need to be and how to get there.

CONCLUSION:

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

To reiterate,

- If we do not use the additional year that CMS has allowed, to establish realistic and enforceable interim milestones for ICD-10 CM conversion, we will find the additional time was wasted.
- CMS must work with the industry to develop meaningful transition steps to maximize the likelihood that the vast majority of providers, health plans, billing companies, clearinghouses, etc. will be able to submit, transmit and process ICD-10 CM claims accurately and seamlessly effective 10/1/2014.
- Limited or lack of end-to-end testing will surely lead to failures. Making and implementing deliberate decisions that have a high probability of failure, such as no external testing, is the equivalent of "reckless disregard."

Sound business principles must be the guiding building blocks for the industry. Every man for himself will not work. We are now at the 11th hour. Little time remains to correct course and make critical and necessary changes. HBMA believes that if ICD-10 CM fails, even in the short term, the industry fails. A significant disruption or cessation of payments to providers is an outcome we cannot afford to allow to occur.

We would also respectfully ask CMS to consider the industry impact of their policy decision on external testing. Will HBMA and other organizations be excited about and willing to collaborate, contribute volunteers, and dedicate time to future CMS outreach efforts if at the end of the day CMS rejects the recommendations of the industry experts from whom they sought help?

The NGS project was met with excitement, active participation, and industry-wide contributions from those in the trenches who really know the business of medicine, practice management, billing, claims adjudication, and payors. The tools developed demonstrate how valuable that work has been and could contribute to a higher implementation success rate for ICD-10 CM. To suddenly undermine that work was a blow to those of us who share in the goal of the most seamless implementation and transition possible.

One year ago at this meeting, the industry collectively said, "We told you so." Please don't let that be the message after October 1, 2014.

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

The Following was recently released by one of Medicare's Contractors:

Testing for ICD-10 Diagnosis Codes:
In preparation for the implementation of the ICD-10 diagnosis codes, Medicare contractors including CEDI will be conducting all testing to assure the ICD-10 codes will be accepted and processed correctly. **CEDI will not be testing directly with Trading Partners, vendors, billing services or clearinghouses prior to the full implementation on October 1, 2014.** If you have any questions, please contact the CEDI Help Desk at ngs.cedihelpdesk@wellpoint.com or at 866-311-9184.