November 25, 2013

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Sent via email: Marilyn.Tavenner@cms.hhs.gov

Dear Administrator Tavenner:

We are writing with regard to the recently announced ICD-10 Testing Week the Medicare contractors have been directed to conduct via Transmittal 1303 dated November 1, 2013 (Change Request 8465). We want to commend you and your staff for recognizing the need for ICD-10 testing; however, we have some concerns about this specific approach to testing, as well as questions about additional testing we trust CMS intends to conduct.

First and foremost, if only one week of testing represents the full-extent of the ICD-10 testing Medicare intends to conduct with providers, then we must prepare for widespread system failures and significant disruption of provider payments on October 1, 2014. This is of particular concern for physicians whose cash reserves are far less able to survive a major shortfall.

HBMA member companies have been working with their physician clients for several years to prepare them for a smooth transition from ICD-9 to ICD-10. We have been active participants in a variety of CMS sponsored ICD-10 educational/implementation initiatives and have appreciated the opportunity to work closely with the CMS staff. We are committed to continuing to guide the provider community to ensure a smooth transition from ICD-9 to ICD-10.

The following questions and observations are submitted for your consideration and action to minimize disruption in the submission of medical claims and ensure their appropriate processing by Medicare, Medicaid, and other third party payors.

We have broken our questions/comments into three categories:

1. Observations About ICD-10 Week;
2. Questions about the ICD-10 Testing Week; and,
3. Long-term questions/comments about additional ICD-10 testing opportunities

We greatly appreciate consideration of these questions/comments by you and your staff.

Observations About ICD-10 Testing Week

First we want to note that the testing activity that will be undertaken during the week of March 3 – 7, 2014 is syntax only testing. Will the provider be able to submit a valid ICD-10 code with a date of service on or after October 1, 2014 and will the MAC's system recognize that as a valid ICD-10 code for the date of service submitted in the 837 file?

"Success" of a test claim (i.e. not rejected) offers no evidence or assurance that an identical live claim will be appropriately adjudicated and appropriately paid – or appropriately denied. Indeed, it would be relatively simple to submit a test ICD-10 claim designed to fail a known edit that would be deemed "accepted" during the "test week" process *only* because it is in the proper format and meets the technical requirements.

According to the Medicare Transmittal as part of testing week, providers will be invited to submit ICD-10 coded claims with dates of service 10/1/2014 or later. Nothing in this transmittal describes any limitations, restrictions, or other constraints on the number, type or location of providers, or limits on the number of test claims that may be submitted. We are concerned that this will present the MACs with an administrative and technical challenge that will be impossible to meet in such a short testing window.

In explaining the purpose of the testing week, the Medicare Transmittal states that the purpose of ICD-10 testing week is to generate "awareness and interest, and to instill confidence in the provider community that CMS and the MACs are ready and prepared for the ICD-10 implementation."

Madam Administrator, the purpose of testing should not be to "generate awareness" or even to "instill confidence" but should be to actually test the process to ensure that it works. If the testing demonstrates that the process works as intended, you *will* instill confidence, but you must also ensure that this is not a false confidence. Are we testing the variables that matter? Are we testing in a way that, to the maximum extent possible, replicates the real world experience of a submitted claim?

For example, the testing week is prior to the deadline for the publication of Medicare's local coverage policies. That is a critical factor in correct claim adjudication. Will Medicare Secondary Payor (MSP) claims process correctly? Will Medicare contractors forward and process claims to the secondary payors correctly? Because certain quality payments, such as PQRS claims based reporting, are contingent on diagnosis codes but payments are not made on the claim 835, how will the providers know those programs have been processed correctly?

We have seen the widespread ramifications of testing that was too little, too late, and too superficial with the Medicare pharmacy program, 5010 and more recently with the Exchange enrollment. Unlike each of these examples, ICD-10 implementation failure equals the cessation of healthcare transactions and payments! True end-to-end testing is absolutely necessary to ensure a successful transition. Merely receiving an answer when we ring the doorbell does not convey any meaningful information about what lies behind the door.

Questions About ICD-10 Week

1. Will testing files include a mix of ICD-9 and 10 codes? It is our considered opinion that even after October 1, 2014, it will be necessary for CMS to continue to receive and process ICD-9

coded claims. Will the ICD-10 Testing Week also test the ability of the MACs to handle ICD-9 coded claims in the new environment?

2. Based on testing history, we anticipate that there will be limits on who or what can be tested. Will the MACs be able to accept claims from any provider type who submits claims to that contractor or will there be limits or restrictions on who can submit, what types of claims can be submitted, etc.? If limited, how and by what criteria will organizations or providers be selected for participation in testing? How will this information be communicated?
3. Will the MACs limit the amount of testing a single provider (or group of providers) can conduct during testing week?
4. Will providers be able to submit bulk/batch claims or will the testing be limited to single claims from a single provider?
5. If the entire provider community is focused on one five day window, the scale/volume of test claims could become overwhelming for some MACs. As we have seen over the last two months, unanticipated volume can severely hinder the ability of the technology to efficiently process information.
6. Testing the limits of the system to handle high volumes simultaneously is an important component of this process. Will the MACs be able to simultaneously handle high volume of processing requests as part of the testing?
7. We notice in the ICD-10 Testing Week announcement that CMS solicits ideas/comments from the contractors relative to additional testing. Will these recommendations/suggestions be made public and if so, will HBMA and other organizations be able to obtain a copy of these recommendations/suggestions?
8. The transmittal does not explicitly state that the provider will be notified of the reason a test claim was rejected, only that they will be notified of the rejection. Will contractors include information in the rejection notice indicating the reason for the rejection? Will they create new reason codes that will be used in production?
9. Will there be a second level of testing with the MACs to ensure that they have properly cross-walked the ICD-9 coded LCDs to ICD-10?
10. Will there be testing so providers will know that their ICD-10 information has been appropriately captured for purposes of meeting the PQRS and other incentive payments based upon diagnosis coding?
11. Will CMS test cross-over claims to ensure that they are appropriately sent and received?
12. Will CMS monitor and assure that non-test claim processing will continue normally and on schedule during the testing week?

Long-term questions/comments about additional ICD-10 testing opportunities

As noted earlier, this level of testing is only for syntax. It tells us nothing about the ability of the MAC to appropriately adjudicate or process the ICD-10 coded claim.

1. Given that many practices may be unable to participate in the March testing week because they will not have received their ICD-10 updates from their practice management vendors, will there be additional opportunities for front-end testing?
2. If a claim file fails, will there be a re-testing period?
3. This will not be a full cycle end-to-end simulated claims submission – from initial connectivity and submission through remittance advice, denials and refund. HBMA and others have, on several occasions, recommended full end-to-end testing of the system, even if only for a representative sample of providers. Will Medicare engage in full end-to-end testing in an

environment intended to closely replicate a real-world experience to ensure that the entire system works?

4. Will results of testing be published so all providers can become aware of deficiencies prior to October 1, 2014?
5. On previous occasions, HBMA and others have made CMS aware that a significant percentage (20 – 25 percent) of claims are submitted and/or processed using the 4010 standards. Payors, including Medicare, are generally not aware of this fact because the clearinghouse and/or practice management vendors these providers use will convert their 4010 to the 5010 platform or vice versa. As you know, you cannot submit an ICD-10 coded claim using 4010. And, unlike converting the 4010 to 5010, the clearinghouse will be unable to convert the ICD-9 claim to ICD-10. Does CMS share our concern that so many providers or payors continue to use 4010 and what do you plan to do to educate these providers or payors about the need to switch to 5010?

Recommendations:

1. A 30 or 45-day testing cycle could mitigate some of the issues mentioned above. This would be particularly true if MACs and providers are able to establish a schedule that anticipates and balances volumes.
2. There must be additional opportunities for front-end testing for those providers not ready to test in early March.
3. Medicare and Medicaid must engage in full end-to-end testing with a representative sample of providers who submit claims to that MAC. This would include not just the providers (hospitals, physicians, clinics, etc.) but also the clearinghouses and billing companies that submit or transmit claims on behalf of these providers.
4. Providers and the medical community must be given specific feedback on the reason test claims were not accepted.
5. Medicare must establish an opportunity for providers to re-test to ensure that any patches or fixes adopted by the MAC and/or provider work as required for correct adjudication.
6. There must be adequate time to remediate identified problems and re-test well before October 1, 2014.
7. CMS should develop a means to publicize the testing status (% of claims successfully tested, for example) of each MAC, DMEPOS, etc.

Conclusion

In the private sector, there is an acronym: TSFF. This stands for Technical Success Functional Failure. In this case, a TSFF would show that everything worked technically, but the claims were not processed or adjudicated correctly. The programs all worked, but the intended end result was not completed, achieved, or delivered.

We are very concerned that absent additional and more robust testing, come October 1, 2014, CMS will be confronted with a TSFF – technically, everything worked fine when tested, but we had a functional failure because claims were not paid properly. We have many lessons learned we can rely upon to avoid this widely anticipated failure. Such an outcome would be disastrous for all providers in the healthcare delivery system.

Thank you in advance for your consideration of our concerns.

Sincerely,

Judson Neal, CHBME
President, HBMA