



October 21, 2008

The Honorable Michael Leavitt  
Secretary  
Department of Health and Human Services  
Attention: CMS-0013-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Dear Secretary Leavitt:

On behalf of the Healthcare Billing and Management Association, we respectfully submit the following COMMENTS. Please note that we are submitting our comments for both the ICD and 5010 transaction code set standards concurrently as we believe these two standards are so intertwined that they must be considered concurrently and not separately. Therefore the same COMMENTS are being submitted to the appropriate address for both proposals.

## **COMMENTS TO PROPOSED ANSI 5010 & ICD-10 IMPLEMENTATION**

### **I. INTRODUCTION**

The following COMMENTS are submitted on behalf of the Healthcare Billing and Management Association (HBMA), the only non-profit association of medical billing professionals. HBMA's 700+ member companies process over 300 million claims annually, employ over 20,000 coders and billing specialists and serve medical practices and non-institutional providers throughout the United States and its territories. The Association has a tradition of education, advocacy and compliance.

In preparing our comments, HBMA consulted with representatives of other health care industry representatives, including: practice management software companies; clearinghouses; professional coders; coding software vendors; electronic medical records vendors and

consultants; professional training consultants; and, practice management consultants. Medical billing companies, like all medical practices and non-institutional providers, rely on a host of vendors, technical and business support products, advisory services and other resources when coding, preparing and submitting claims, receiving and processing claim determinations and payments, managing accounts receivable, reporting and data analysis and host of other day-to-day activities. We did not wish to offer myopic or one-dimensional comments, preferring to give HHS a broader assessment of the global effects of their proposed regulations.

## **II. OVERVIEW**

### **5010 TRANSACTION STANDARDS**

The implementation, evolution and growth of electronic claims processing has been slower and taken much longer than most of our members would have liked. The benefits promised by the implementation of the HIPAA Transaction Code Set (TCS) have benefited the health insurance industry and the contractors serving Medicare and Medicaid, but there have been few benefits realized by providers and HBMA members, primarily because there were no benefits or incentives for the payers to support the eligibility verification, payment determination or claim query features of the HIPAA TCS. Operationally, most practices' and billing companies' claim processing is little more automated in 2008 than it was in 2003.

Because HHS has allowed payers to deviate from the HIPAA TCS by the utilization of "companion guides" our members find themselves dealing with more unique electronic transactions – to and from payers – than they did before HIPAA TCS. The consequence of HHS' less-than-strict application and enforcement of the 4010 and 4010A transaction standards – even among CMS contractors – is that providers, clearinghouses, software vendors and others have had to build, operate and maintain a patchwork of "work-arounds" and non-standard transactions in order to sustain their cash flow.

The vast majority of hospitals utilize commercial software to perform their billing functions, although there remains a scant minority with proprietary systems. The number of hospital software vendors is small – fewer than twenty large vendors account for over 90% of all hospitals' billing and financial management systems. Similarly, most physicians and other non-institutional providers utilize commercial software systems to perform their billing and accounts receivable functions; it is similarly, if not more rare for these providers to operate proprietary systems. However, unlike hospitals, physicians and non-institutional providers use several

thousand different billing software packages, many of which are focused on certain specialties, geographic areas, practice sizes, delivery modes (“in house,” ASP, batch, etc.), and other variables. It is noteworthy that there are no software products specifically developed for medical billing companies; among HBMA’s 700+ member companies, there are over 300 different software systems being used today. The diversity and number of systems used by individual medical practices is even greater.

While the past decade has seen a great deal of consolidation among physician practice software vendors, the numbers cited above are post-consolidation. Concurrently, there have been some company and product failures; the HIPAA TCS transition resulted in some vendor attrition, forcing customers of those products to select and migrate to a replacement system, often at considerable cost and disruption of their cash flow.

Migration to the so-called ANSI 5010 transaction codes represents a major step forward in the ability of all billing-related transactions to be more complete, more flexible, more accurate, more “granular,” and adaptable to future changes. For these reasons, we welcome the prospect of a successful migration to the 5010 transaction standards, but worry that without universal adoption and the complete elimination of permissive deviations (“companion guides” or their equivalent), combined with HHS’ more assertive enforcement of compliance by all payers, we will be left with more complexity and no benefits to offset the considerable transition costs.

## **ICD-10 TRANSITION**

Every healthcare provider submits payment requests (claims) using a pair of numeric code “languages:” the American Medical Association’s CPT codes or CMS’ HCPCS codes, which have codified services and products; and, ICD-9 CM, DSM IV or ADA codes which have codified the diagnoses related to those services and products. Together, these coding systems have been the “language of billing” for over five decades. While there have been annual changes to both systems since they began, even when those changes have been substantial – such as in 1992 during the implementation of the RBRVS codes – the changes have been evolutionary, rather than revolutionary. The structure and character of both coding systems have remained constant, allowing those using these codes to build a well-established body of knowledge, as well as: proven training programs; coder testing and certification programs; books, manuals, reference guides, general and specialty newsletters, web sites and a host of other coding resources for providers, coders, billing specialists, compliance officers and others.

HHS and others have frequently cited the fact that the United States is the only country still using ICD-9 CM, noting that all other World Health Organization (WHO) member nations adopted ICD-10 ten or more years ago. Seldom mentioned is the additional fact that the United States is the *ONLY* country that utilizes diagnosis coding as part of the payment methodology for healthcare services and that ICD-9 CM is a primary wheel in America's health care financial machinery. Changing that primary wheel – while the machine is in motion, at full speed – is an undertaking of enormous gravity that could paralyze America's entire health care system if the transition is not flawless. We have recently seen medical practices bankrupted or closed by poorly executed NPI implementations and Carrier/MAC transitions; a change to ICD-10 is of such significance that the success rate must be nearly flawless to preserve and assure the financial stability of medical practices.

Moving from ICD-9 CM to ICD-10 is analogous to converting from “English” measurements (inches, feet, yards, miles; ounces, pounds, tons; quarts, gallons) to “Metric” measurements (millimeters, meters, kilometers; kilos; milliliters, liters, etc.). Use of ICD-10 does not change what is being recorded – translating the narrative description of a patient's diagnosis to code – but the language is changing completely. High levels of ICD-9 CM “fluency” will not provide any assurance of rapidly gaining an equal level of “fluency” in ICD-10. Health care providers and their staffs, all of whom have utilized ICD-9 CM for, literally, their entire careers, must now learn an entirely new language that is a critical element in the financial operation of their organization.

HBMA does not oppose moving from ICD-9 CM to ICD-10, but we are concerned that:

- There is little, if any, benefit for patients produced by the new coding system;
- There is little, if any, benefit for providers produced by the new coding system;
- The costs of transition and implementation to providers are considerable, yet there is no provision in the NPRM for funding assistance for providers;
- The post-implementation results do not propose greater payment levels or any prospect of faster claim processing, higher levels of “clean claims” or any other economic or other tangible benefit that might offset or recover some of the implementation and transition costs;
- Much of HHS' assessment of transition and implementation has focused on hospitals. Clearly, there is a disproportionately high level of Medicare funds associated with hospital claims, making hospitals an important aspect of the ICD-10 transition, but hospitals also have disproportionately high operating budgets and internal resources to

address such changes. Physician practices and other non-institutional provider do not, yet their costs will be disproportionately high;

- The proposed implementation timetable for ICD-10 will not provide sufficient time for the proposed 5010 TCS transition to “shake down” and the overall schedule is too rushed, particularly because there is no specific basis for greater urgency;
- HHS has dramatically under-estimated the costs associated with the transition to both ANSI 5010 and ICD-10 and this miscalculation will lead to significant and possibly unsustainable costs to medical practices;
- HHS has an overly simplistic appreciation of the time and training required for providers and their staffs to become fluent with ICD-10. It is important to note that practices have seen significant declines in their gross and per-patient income over the last decade (non-CMS related, as well as CMS related reductions), forcing staff reductions and necessitating a greater focus on employee productivity, particularly among coding positions, which tend to be more costly. Declines in coding productivity will translate directly into slower and/or lost income as well as greater operating costs.

### **III. BILLING SYSTEMS**

The majority of medical billing companies, like their physician clients, utilize commercial “practice management systems” to perform their billing functions. The number and variety of available systems represents one of the greatest challenges and concerns for HBMA members: whether, when and at what cost will their particular vendor be ready to support the new 5010 transactions and/or ICD-10.

Past experience has shown that mandatory changes, such as HIPAA TCS and NPI, have led some vendors to exit the market, forcing their customers to secure a replacement, often with little, or last-minute, notice. In other cases, vendors have engaged in exploitative conduct, increasing their prices by exorbitant amounts, leveraging oppressive new contract terms into their contracts, or both. Our members are apprehensive that if too little time is allowed for each separate transition, some vendors will, again, use the changes to exploit them at a time when implementing an alternative will be problematic.

Even when there is a fully engaged vendor/customer partnership, any transition of the magnitude of either of HHS’ proposed initiatives (5010 or ICD-10) represents a significant challenge for all concerned. Successful sequential implementation of two interdependent initiatives calls for much greater care and planning than might be necessary, if they occurred alone.

Some commercial vendors are already touting that their product is “ICD-10” compliant, yet close questioning by those familiar with ICD-10 determined that these products may be “ready to be compliant,” but are not compliant now. These dynamics are mentioned to illustrate that HHS’ two proposals have a dramatic effect on the marketplace and are far more than just “a few mechanical changes” to the diagnosis coding process.

#### **A. ANSI 5010 TRANSACTIONS**

**COMMENT 1:** HBMA objects to HHS’ proposed timetable for 5010 implementation and firmly believes that a 2010 “live” date: **a)** is too fast for all parties to adequately prepare, test, adjust, retest, readjust and validate; **b)** proposes a “big bang” approach, under which everyone will launch simultaneously, without prior testing of each component, working from the end (payers) backwards to the beginning (providers); **c)** underestimates the intricacy and complexity of newly added data elements and their effect on claims preparation and submission, particularly when many of the new features of 5010 will apply to a very limited number of settings and claim types. Our members and their provider clients have clear memories of the disarray, confusion and income disruptions caused by implementation of the current Transaction Code Set and trust that one of HHS’ goals is to avoid repeating those problems.

**RECOMMENDATION 1A:** HBMA is aware of and agrees with the assessments of the National Committee on Vital and Health Statistics (NCVHS) and the Workgroup for Electronic Data Interchange (WEDI), each of which has concluded that 5010 implementation should be at least 24 months following the date of published final regulations. In addition, we believe that the final regulations should include provisions for extensive, certified testing and that the final commitment to “go live” should be based on meeting a publicly verified readiness percentage of all major payers, even if meeting that percentage requires extending the live date.

**RECOMMENDATION 1B:** We recognize that there will be a post-live period of adjustment and fine-tuning of 5010 transactions. However, we recommend that as a prerequisite of proceeding forward with live implementation of ICD-10 codes there should be wide and common agreement that 5010 transactions are working well for all, or nearly all, providers. Furthermore, we recommend that implementation of ICD-10 have, as an absolute prerequisite, the elimination of all “companion guides” among all federal and non-federal payers. Unless or until companion guides are fully eliminated, implementation of ICD-10 should be delayed; failure to achieve this important goal will, we believe, jeopardize the essential success required to prevent widespread financial impairment of physicians and non-institutional providers.

## **B. ICD-10 IMPLEMENTATION**

Reporting a patient's diagnoses is a required component of successful claim submission. Without complete and accurate diagnosis information, insurers will delay payment, or refuse to pay entirely. Implementation of ICD-10 will, therefore, equate to a life or death step in the financial health of a practice. And, because nearly all outsourced billing relationships are based on a percentage of funds collected, HBMA members' interests are identically aligned.

### **HIPAA-EXEMPT PAYERS**

**COMMENT 2:** HHS' proposals make no mention of insurers that are exempt from utilizing HIPAA transactions. It is unclear whether that omission was intentional or an oversight, but the existence of two important HIPAA-exempt payer classes raises a very significant complication for providers. Both auto insurers and workers compensation plans are generally exempt from HIPAA and, to some extent, tort liability insurers are, as well. All HIPAA-exempt payers accept ICD-9 CM diagnosis codes and will not be statutorily obligated to implement ICD-10. In view of the considerable costs associated with ICD-10 implementation, we believe that all, or many, of these insurers will continue to expect ICD-9 CM codes and will not accept ICD-10 codes, thereby creating an ongoing, long-term dual-code environment. The "retirement" of ICD-9 CM by the WHO will simply freeze those codes in time and will not necessitate use of ICD-10.

Rewriting billing software for ICD-10 compliance will be a daunting task; continuing to support ICD-9 CM as well as ICD-10 increases the complexity of this by several orders of magnitude. For example, many patients go to their primary care physician for injury-related services, but may also be receiving ongoing care for other, non-injury related routine or chronic medical problems. Creating a "split claim" will require processing and submission of two separate diagnosis code(s). The programming required to support this common scenario will be expensive, time consuming and will require extensive testing and pre-implementation user training. It is our belief that HHS' economic impact estimates did not account for these very significant additional costs, which will affect programming, testing, product/user documentation, technical and user training and ongoing support, indefinitely into future.

**RECOMMENDATION 2:** HBMA recommends that HHS evaluate this aspect of ICD-10 implementation and calculate and recognize the costs associated with operation of a dual-code system. HBMA will be happy to assist HHS in this undertaking.

## **ICD-9-CM HISTORY ACCESS**

**COMMENT 3:** Many practice management systems are designed to support the continuity of a patient/provider relationship over long periods of time. As a result, implementation of ICD-10 will require that these systems devise a means of maintaining availability of patients' historic ICD-9 CM data. This might be achieved through devising an "ICD-9 CM/ICD-10 Crosswalk," although we have been informed by many coding experts that this will be highly problematic, if not impossible. If a one-time data conversion is not possible or economically feasible, the alternative must be to maintain ongoing support of both coding schemes, because the alternative is to forfeit one of the important clinical support features of the provider's system.

Our members have noted that, in addition to claim submission, stored diagnosis codes are integrated into legacy claims, research databases, drug interaction software, patient clinical (diagnosis) profiles, provider case profiles, planning and reporting tools and a variety of other clinical and practice management system features.

In the absence of a direct, one-to-one crosswalk of ICD-9 to ICD-10 and ICD-10 to ICD-9 codes, every computer system that utilizes ICD codes in any way will have to maintain tables for both versions of ICD in order to process the data coming in and going out of that system. In addition, any cross-walk tables and any programs that utilize the codes will have to be modified to be date sensitive, so that transactions occurring prior to and after the ICD-10 implementation date will refer to the correct tables when diagnosis-related data are processed following the ICD-10 effective date. Definition of an "ICD-10 date" (for example, a date of service, date claim created, date claim transmitted, or date claim received by payer) should be established to enable all systems to process the correct code type on the same basis and to avoid further industry confusion. The type or purpose of the computer program/application does not really matter, as any transaction involving ICD codes will have to be processed by the system according to the "ICD-10 date".

Most practice management systems are not able, and may not have the ability to be altered, to use date sensitivity to identify and accurately process ICD code transactions when there are 2 sets of codes. This means that arbitrary logic will be implemented by many system administrators and developers that will, for example, apply ICD-10 codes to all transactions that occur after the "ICD-10 date".

The ICD-9 tables will have to be maintained in most, if not all, systems for a very long time to meet a number of needs such as:

1. Referential integrity – to validate ICD-9 codes against the table whenever ICD-9 codes are “called” in a system for any reason.
2. Resubmission of healthcare claims for dates of service prior to the “ICD-10 date” after ICD-10 has been implemented.
3. Historical reporting for providers and others when the reporting period reaches back into time prior to the date ICD-10 is implemented.

Finally, the structure of ICD-10-CM codes compared to ICD-9-CM will require complex changes to online transaction processing edits in systems. The ICD-10-CM code structure is not only longer (up to 7 positions compared to 5 positions) but the attributes of each position are, or can be, different. For example, where the first position in the ICD-9 version is either alpha or numeric, that same position in ICD-10 is always alpha and the last 4 positions in the ICD-9 version are always numeric those same positions in the ICD-10 version can be either alpha or numeric. Systems that edit entry of codes based on structural criteria, along with other edits, will have to undergo extensive modification to perform edits for both versions.

It is our belief that HHS’ economic impact estimates did not account for these very significant additional costs, which will affect programming, testing, product/user documentation, technical and user training and ongoing support, indefinitely into future.

**RECOMMENDATION 3:** We recommend that HHS evaluate this aspect of ICD-10 implementation and calculate and recognize the costs associated with operation of a dual-code system. HBMA will be happy to assist HHS in this undertaking.

## **CODING SUPPORT SOFTWARE**

**COMMENT 4:** Coding has, for over a decade, represented one of the most significant compliance risks areas for all providers, as cited by the HHS OIG, U.S. Attorneys and CMS. To proactively deal with these risks, a number of coding support software products are now offered by companies that are not in the practice management (PM) software business. These coding products are “bolted on” to (interfaced, not integrated) a providers’ billing system. Because each system will likely address ICD-10, but almost certainly in different ways, the system-to-system interfaces will all have to be rewritten. The features, capabilities and pricing of these coding software products vary widely, however, the cost-per-provider is estimated to be \$500 to \$1,000 per provider. Our members have noted that small (less than 4 providers) office-based practices seldom purchase these products, deeming them “too expensive.” It is our belief that HHS’ economic impact estimates did not account for these very significant additional costs,

which will affect programming, testing, product/user documentation, technical and user training and ongoing support.

**RECOMMENDATION 4:** We recommend that HHS evaluate this aspect of ICD-10 implementation and calculate and recognize the costs associated with operation of a dual-code system. HBMA will be happy to assist HHS in this undertaking.

#### **EMR/BILLING SYSTEM INTERFACE**

**COMMENT 5:** Similar to the coding support products mentioned above, office-based physicians (unlike hospital-based physicians, for whom Electronic Medical Records (EMRs) are always supplied by the hospital) have begun to consider the purchase and adoption of EMRs. A recent market survey identified over 425 commercially available EMR products and few, if any, are currently able to support ICD-10, a need we believe these vendors will address in due course, although industry experts predict that vendor attrition will increase over the next three years, simply as part of normal business cycles. In addition, adoption and implementation of EMR systems among office-based physicians remains below 20% despite years of marketing by some vendors and considerable encouragement – but no funding – by the U.S. government. Recent negative economic developments strongly suggest that providers will be loathe to commit scarce financial resources to EMR for the immediate future, or longer. HBMA believes that these factors, taken together, demonstrate that EMR systems will not represent a relevant tool for over 70%+ of office practices in adapting to ICD-10.

Many EMR products are independent of, and do not incorporate, a billing capability, while others offer a billing capability which may, or may not, be utilized if that practice already has a well-established billing system in place. As a result of these variables, many EMRs will have to be interfaced and/or integrated into a practice's billing system in order to pass the CPT and ICD-10 data to the billing system, as well as receive edited data back from the billing system, based on claim rejections.

EMR systems and any of their data trading partners such as practice management systems, lab systems, hospital systems, and other EMR systems will be required to maintain both ICD-9 and ICD-10 tables in order to accommodate data transactions that pre-date implementation of ICD-10 and post-implementation of ICD-10. All interfaces will have to be modified, if already in existence, or created, if new, to be able to recognize and deal with both versions of the codes. Again, perhaps the best way to accomplish this is to set a date that can be used in a date sensitive manner to discriminate between which code should be used for each transaction. HL7 already

appears to accommodate ICD-10 codes so the standard itself, when used in interfaces, may not have to be updated; but the thousands of interfaces in existence WILL have to be updated at great cost.

Because many practice management and EMR vendors may not have the personnel or financial resources to accomplish the required updates, many providers will be forced to deal with situations where one or more of their mission critical systems will be unable to process transactions containing ICD-10 data. This will be disruptive and create a “Catch 22” situation where the providers cannot complete medical, legal, and/or financially critical transactions.

It is our belief that HHS’ economic impact estimates did not account for these very significant additional costs, which will affect programming, testing, product/user documentation, technical and user training and ongoing support, indefinitely into future.

**RECOMMENDATION 5:** We recommend that HHS evaluate this aspect of ICD-10 implementation and calculate and recognize the costs associated with operation of a dual-code system. HBMA will be happy to assist HHS in this undertaking.

#### **CLAIM SUBMISSION**

**COMMENT 6:** The submission of claims occurs in many forms. The volume and percentage of claims submitted electronically has grown over the past ten years, but remains well below 100%. Not only are there practices without computers, there are insurers that continue to require copies of patient records as part of claim adjudication. While one of the goals of the ANSI 5010 transaction set is to facilitate electronic attachments, many practices do not have – nor plan to have – scanning technology that could take advantage of electronic attachments. The result of these factors will be the ongoing need for billing systems to have the ability to support the printing of paper claims and, as noted earlier, the ability to print ***BOTH*** ICD-9 CM and ICD-10 diagnosis codes.

In addition, many patients’ claims must be split to accommodate multiple insurers (as noted earlier) as well as primary and secondary insurers that often have dissimilar submission requirements (electronic vs. paper). For these reasons, billing systems will have to develop and maintain the ongoing ability to produce claims in both formats, often interchangeably, to support varying claim submission requirements which frequently vary according to the types and/or locations of services rendered.

Every practice management/billing system in production prior to the implementation of ICD-10 will have to be modified to accommodate the new version as well as to continue to support the current version. A lesson to be learned from the NPI experience, as it was a huge issue during implementation of NPI, is the need to have a nationwide bulletin board or information exchange of some form to allow every payer to update its readiness for ICD-10 and ANSI 5010. Beyond the fundamental program modifications necessary to conform to the new specifications, probably the hardest issue in successful implementation will be the knowledge of when each payer is ready to accept ICD-10 codes on claims. It is one thing to set a deadline, but NPI showed us that a number of payers began requiring NPI PRIOR to the deadline and the same should be reasonably expected to occur with ICD-10. The knowledge of what format to send to a specific payer (ICD-9 or ICD-10/ANSI 4010 or ANSI 5010) makes the administration of this much more manageable and less subject to errors that frustrate providers and cause delays in important cash flow.

Standardization of the requirements that payers can impose on submitters is also essential. Again, the NPI experience taught us that some payers still required legacy provider numbers in addition to NPI or some payers would require codes to be transmitted in various fields/loops in the claim record. If payers are allowed to impose esoteric requirements to, for example, send both versions of the ICD codes (which would be impractical) or to unilaterally establish different dates as the cutoff for claims to include ICD-9 codes, this would become completely unmanageable for providers and their respective billing systems.

It is our belief that HHS' economic impact estimates did not account for these very significant additional costs, which will affect programming, testing, product/user documentation, technical and user training and ongoing support, indefinitely into future.

**RECOMMENDATION 6:** We recommend that HHS evaluate this aspect of ICD-10 implementation and calculate and recognize the costs associated with operation of a dual-code system. HBMA will be happy to assist HHS in this undertaking.

## **CODING EDITS**

**COMMENT 7:** The preparation and submission of claims involves anticipating and/or pre-screening claims to establish, in advance, whether the claim complies with: CCI edits; Local Coverage Decisions (LCDs); National Coverage Decisions (NCDs); and many hundreds of individual payer-specific coverage and adjudication requirements. Billing software vendors and independent "claims scrubbing" software systems will have to amend or completely rewrite their

systems to accommodate ICD-10, while continuing to maintain their support of ICD-9 CM for non-HIPAA payers. In addition, there are frequent occurrences where patients have multiple insurers and/or split claims going to different insurers for discrete services.

Because these policies and edits are all date sensitive, they will be particularly difficult in dealing with the ICD-10 transition. Probably the largest burden will be on the “owners” of the various policies and edits and their ability to update them with sufficient lead time prior to the ICD-10 date to allow the various systems that use them to update and test the new tables. The systems that use this data will have to modify their tables that store the data and the programs that read and logically use the data in processing transactions.

A significant decision will be the choice between creating an expiration date for all current policies and edits that mimics the ICD-10 date, again assuming that one will be established, so that the ICD-10 related policies and edits will have a common start date and the other option of updating all of the historical edits with the new ICD-10 codes. The latter option would be disastrous to the industry.

Similarly, there are a host of “denial management” software products designed to allow providers to recognize and address denied claims, including submission of appeals. Once again, these systems will have to maintain the capability to support both ICD-9 CM and ICD-10 in order to bridge the implementation of ICD-10 and for quite some time thereafter. In addition, there remains the ongoing need to support non-HIPAA claim requirements.

It is our belief that HHS’ economic impact estimates did not account for these very significant additional costs, which will affect programming, testing, product/user documentation, technical and user training and ongoing support, indefinitely into future.

**RECOMMENDATION 7:** We recommend that HHS evaluate this aspect of ICD-10 implementation and calculate and recognize the costs associated with operation of a dual-code system. HBMA will be happy to assist HHS in this undertaking.

## **PATIENT STATEMENTS**

**COMMENT 8:** Part of the billing process always includes billing the patient for their share of a medical bill – except, of course, for most Medicaid patients. One of the many variables desired by practices and billing companies is the ability to (optionally) supply the patient with their diagnosis information, either in code(s) and/or narrative. To address space and complexity challenges, many practices have adopted a translation tables that provide the patient

with accurate, albeit generalized, information about the diagnosis for a service. 21<sup>st</sup> century patient statements are gradually moving towards “electronic presentment” – billing to patients’ email address, although the majority remain on paper.

We are concerned that the work required translating almost ten times the number of diagnosis codes will prove to be an insurmountable task, rendering this aspect of patient communication inoperative. We recognize that there is no alternative, but we wanted to make you aware of this unintended consequence of any transition to ICD-10. To the extent that commercial software companies, patient statement vendors (the majority of patient statements are processed by subcontractor companies, not the practice or software vendor) and others can devise solutions to this challenge, considerable time and money will be devoted to preserving an existing system capability. It is our belief that HHS’ economic impact estimates did not account for these very significant additional costs, which will affect programming, testing, product/user documentation, technical and user training and ongoing support, indefinitely into future.

**RECOMMENDATION 8:** We recommend that HHS evaluate this aspect of ICD-10 implementation and calculate and recognize the costs associated with addressing patient communication and monthly statements. HBMA will be happy to assist HHS in this undertaking.

## **REPORTING AND DATA ANALYSIS**

**COMMENT 9:** As noted previously, some medical practices and billing companies implemented practice management systems more than 20 years ago. This has resulted in the development of a rich store of information that is valuable to the patients, the practice and to some researchers. In order for these data to remain an asset to all three constituents, it must remain searchable and usable. We are concerned that the modifications required to preserve this capability will prove to be costly and time-consuming for the vendor and/or practice, particularly for those practices that have a proprietary billing system. Should we lose the capability to data mine these resources as a consequence of ICD-10 implementation, the “cost” could be incalculable.

This is an area where the level of effort and cost to systems generating reports containing ICD code information will be staggering, and could even put some system vendors out of business. The sheer number of reports that will have to be “touched” by someone to alter them to accommodate ICD-10 is, by itself, stunning. Not only will reports have to be modified to expand the size of the columns/data elements on reports containing ICD codes, but many of those reports

will already be so packed with information that there will simply not be sufficient “real estate” on a formatted report to handle that expansion without sacrificing other important information on the report.

Historic data compatibility shouldn't be a technical issue because the field size for ICD-10 is larger than what is required for ICD-9 CM. However, the size of reports containing ICD codes will increase enormously for several reasons:

1. The greater number of ICD-10 codes will tend to make reports larger and longer.
2. The need to display both ICD-9 CM and ICD-10 codes, at least for the first years after adoption of ICD-10, will have the natural effect of making the reports larger.
3. Any reports that report on matches between CPT and ICD codes will become exponentially larger because there will be so many more code combinations, particularly when still reporting on both ICD-9 and ICD-10 codes.

This will have significant environmental impact when the number of reports that will be actually printed on paper is taken into consideration.

It is our belief that HHS' economic impact estimates did not account for these very significant additional costs, which will affect programming, testing, product/user documentation, technical and user training and ongoing support, indefinitely into future.

**RECOMMENDATION 9:** We recommend that HHS evaluate this aspect of ICD-10 implementation and calculate and recognize the costs associated with data analysis and reporting, as well as the impact of a dual-code system. HBMA will be happy to assist HHS in this undertaking.

## **PQRI SUPPORT**

**COMMENT 10:** CMS' PQRI initiative may or may not be in operation in 2011 or after. If it is, PQRI relies on diagnosis data and ICD-10 may offer greater accuracy and levels of detail not currently possible. However, in order for PQRI to operate, all of the measures will have to be rewritten and much more specificity will be required. The costs associated with this transition will be incurred by CMS as well as the provider community – the latter directly or through their vendors. We believe these costs will be material for both sides of this program. It is our belief that HHS' economic impact estimates did not account for these very significant additional costs,

which will affect programming, testing, product/user documentation, technical and user training and ongoing support, indefinitely into future.

**RECOMMENDATION 10:** We recommend that HHS evaluate this aspect of ICD-10 implementation and calculate and recognize the costs associated with the ICD-10 transition on PQRI measures and their reporting. HBMA will be happy to assist HHS in this undertaking.

#### **IV. IMPLEMENTATION and TRANSITION COSTS**

**COMMENT 11:** HBMA is aware of various professionally conducted studies of the estimated implementation costs associated with ICD-10. We have reviewed the reports of those studies, including: the Rand Study conducted for the Blue Cross Blue Shield Association; the Hay Group, Inc. study conducted for America's Health Insurance Plans (AHIP) in October 12, 2006; the IBM Corporation study: Impact Of ICD-10 Code Set Adoption On Health Insurance Plans dated May 1, 2006; and, the Nachimson Advisors, LLC Report The Impact of Implementing ICD-10 dated Sept 5, 2008. Despite the fact that there were dissimilar methods employed by each study, the universal conclusions were that HHS' estimates of implementation costs are fatally flawed and are wholly unreliable.

Puzzled by the dramatic disparity in the results of these studies with HHS' analysis, we also reviewed the AHA/AHIMA study conducted in 2003. We discovered that only 3% of the data in the AHA/AHIMA study represented physician or non-institutional providers and that there was virtually no representation of ambulance, DME, ambulatory surgery center, Rural Health Clinic/Federally Qualified Health Center, Imaging Center or IDTF or commercial laboratory, to name a few of those omitted. It would appear that the 2003 study was, effectively, a "proof of concept" study primarily focused on hospital coding requirements but this report's data became the baseline for HHS' NPRM cost impact estimates.

Our conclusion is that while the AHA/AHIMA study may shed some light on the impact of ICD-10 for hospitals, it is a highly unreliable with respect to cost and time relative to non-hospital settings. Reliance upon the AHA/AHIMA study for other providers was inappropriate. We believe the studies mentioned above reflect a more realistic estimate of ICD-10 implementation costs for non-hospital providers.

There are varying estimates of the number of actively practicing physicians in the U.S. – from slightly under 800,000 to over 1,000,000. Some of our members believe that the total ANSI

5010 and ICD-10 transition costs incurred by each physician will exceed \$1,000, while others believe the costs may be as low as \$300 per physician. Thus, the range of total costs may be as low as 800,000 x \$300, or \$2.4 billion to as high as 1,000,000 x \$1,000, or \$10 billion. As stated elsewhere in this document, HBMA did not have the time or resources to sponsor our own assessment, but the simple calculations above are more consistent with the other commercial studies than with HHS' estimates.

**RECOMMENDATION 11:** HBMA recommends that HHS conduct or commission a study of the functional requirements and costs to provide ICD-10 training and education for physicians and other non-institutional providers. In addition, we believe that a variety of approaches and methodologies should be tested for effectiveness, such as: video programs (CD, DVD, Blu-Ray, etc.); web casts and audio casts [live and/or recorded]; classroom training; manuals, books and other print format materials; training exercises, peer-to-peer training, etc.

## V. CODING

### A. **Training**

**COMMENT 12:** As noted earlier, accurate coding is not only essential for proper billing and reimbursement, it is also a critical component of all practices' compliance process. Implementation of ICD-10 will demand that coding accuracy remain equal to current levels or surpass it. Any undertaking of the magnitude of ICD-10 implementation will require training for every individual who uses or has any interaction with diagnosis coding, from the documentation of the diagnosis through the closing of a paid or denied claim.

HBMA believes HHS has significantly underestimated the required training time necessary for comprehensive knowledge and accurate implementation of a new coding system. The studies relied upon by HHS are based on facility coding, using experienced coders. While we believe an estimate of a minimum of sixteen to twenty four hours is reasonable to learn the basic concepts and glean a basic understanding of the coding conventions, it is not reasonable to expect an initial high accuracy percentage or the in-depth knowledge many coders currently demonstrate.

Any training estimate is increased exponentially when training non-professional coders, a common characteristic in physician offices. ICD-10's increased specificity, required clinical and medical terminology knowledge and understanding of medical technology will require extensive education and the need for coding support software. Because encoders and other automated

coding products are rare in a physician office setting, availability and affordability are very real concerns that have not been addressed by HHS.

In addition to the coder of the encounter, comparable expertise will be required at the payer. We do not believe HHS has adequately investigated, estimated or addressed these training requirements and has not given consideration to the payer implementation requirements and costs.

HHS has advocated a date certain implementation to avoid the complexities and confusion of utilizing both ICD-9 and ICD-10. The reality is that both systems will need to be maintained and used for an undetermined and indefinite period of time. Entities not subject to HIPAA standard transaction sets, DOS coding requirements, payer policies, etc. will all require using and having expertise in both coding systems and conventions.

**RECOMMENDATION 12:** We recommend an extended implementation schedule until 2014, with verification of readiness prior to implementation.

## **B. Physician Education**

**COMMENT 13:** HHS' belief that physicians will utilize a superbill for diagnosis coding and that minimal training will be required demonstrates an unrealistic view of how ICD-10 coding will impact practices.

First, hospital-based physicians (Radiology, Emergency Medicine, Anesthesiology, Pathology) rarely use a superbill, as their services are predominantly coded by staff coders. Second, the raw volume of ICD-10 codes – a 5X multiple or more of ICD-9 CM codes – would require adding three to five PAGES to a one-page superbill in order to offer the same current choices.

It is true that many physicians rely upon simple check-off forms or superbills. The typical form includes fewer than fifty diagnosis codes with the vast majority of diagnosis codes “unspecified” (ending with a 0 or 9). While it may be possible for a single specialty, with relatively limited diagnoses, to have such a tool utilizing ICD-10, it is impractical for physicians who serve a wide variety of patients and associated conditions. We agree that providers should report the increased specificity ICD-10 can support, but a check off list or superbill will not be realistic for most providers. If all unspecified codes will be acceptable, the goals of ICD-10 are rendered

moot and the enhanced information and details will be non-existent in the physician office environment.

The assumption that no provider training will be required is disconcerting. Further complicating this challenge is the fact that most physicians do not know the current ICD-9 coding nuances and cannot be expected to easily learn the ICD-10 coding conventions. Some ICD-10 coding guidelines are in direct conflict with current conventions and long standing Coding Clinic (published by the AHA – [American Hospital Association]) instructions, i.e. coding unconfirmed diagnoses in the physician office setting, is a complicating factor that requires specific education. While HHS may provide ICD-10 education, it is rare for physician practices to purchase expensive coding publications, such as Coding Clinic, and many small practices do not receive on-line education. HBMA believes adequate education, training and coding tool development will require significantly more time than HHS has estimated, and at substantially greater costs than the agency has estimated.

Statements in the ICD-10 NPRM regarding the requirements for physician training completely ignore the most significant educational requirement: many, if not most, physicians do not currently record (whether written, dictated or EMR) with the specificity required by ICD-10. For example, physician documentation may state, “CVA” (Cerebrovascular Accident) but it does not typically state which intracerebral artery caused the stroke.

Extensive education, training and follow-up will be necessary to teach physicians how to accurately document for ICD-10 code assignment. This will require a planned approach that incorporates how documentation is currently prepared, education regarding the new terminology and specificity required in the clinical record, modifications to templates and EMR, etc. HBMA believes this training will require an extended period of time and will routinely require multiple iterations and follow-up reviews. An updated superbill will not solve the need for medical record documentation. We do not believe the costs for this initiative have been evaluated by HHS or included in the overall costs in HHS’ impact estimates.

**RECOMMENDATION 13:** HBMA recommends that HHS consider making provider education funds available to assist with the successful implementation of ICD-10. Among the possible approaches that might be considered are: training grants to state Medical Associations, clinical specialty organizations and others so that they might offer free programs for their constituents if the program content meets or exceed HHS standards; federally-sponsored and/or presented training programs such as

### **C. Office Staff**

**COMMENT 14:** Many physician offices do not employ professional or certified coders. Unless the codes are assigned by the physician or a nurse, staff knowledge of medical terminology, anatomy and physiology, pathology, clinical practice, medical record interpretation and medical technology is very limited. Most physician practices do not use and cannot afford automated coding software or encoders. The typical coding resources are a CPT and ICD-9 book. Subscriptions to professional coding journals are rare and many do not subscribe to payer bulletins.

The ability of physician staffs to accurately report ICD-10 codes has not been tested or adequately addressed. Errors, misunderstandings, and innocent mistakes may create claim denials and financial disruptions. More importantly, medical liability and/or compliance risks may be created for the practice by improper and inaccurate reporting resulting from a lack of knowledge and coding expertise. Physician practice “coders” cannot be assessed or estimates made based on hospital coders, who are typically certified professionals using coding support software products. These very different training and educational requirements have not been addressed in HHS’ NPRM, but must be if ICD-10 implementation is to succeed.

**RECOMMENDATION 14:** We recommend that HHS more fully assess the training and education needs of non-institutional providers, including office-based physicians, as well as hospital-based physicians in order to understand and address their needs and the costs of meeting those needs if a transition to ICD-10 is to be successful.

### **D. Professional Coders**

**COMMENT 15:** As discussed above, HBMA concurs with adult education estimates that a minimum of 16 to 24 hours for initial education should be adequate for experienced professional coders to understand the basic conventions and concepts of ICD-10. Coding industry experts maintain that an additional 30 hours may be necessary to appropriately train even experienced coders on ICD-10-CM transition. HBMA has no reason to doubt this number. HBMA also concurs with a Canadian study ("Implementation of ICD-10-CA/CCI in Canada: A Continuous Journey." July 2002. Mea Renahan) that three to six months will be required to regain the current coding productivity levels. These estimates are consistent with HBMA member input regarding the time required for internal training and monitoring accuracy of newly hired coders, which is typically six months. In addition to learning a new coding system, even experienced

professional coders will need to become familiar with the increased terminology, as well as the clinical and technology requirements imposed by ICD-10. These potential educational deficiencies and the associated costs have not been adequately addressed for the physician and non-facility settings. The training and productivity rebuilding period will negatively impact cash flow and practice expenses while the necessary expertise and production are achieved. We do not believe HHS has allowed for, or given adequate consideration to, how to support physician practices during this lost production period.

Not all professional coders use or rely upon automated coding tools or coding software. The magnitude of an increased number of codes, from ~13,000 to more than 68,000, will require the professional coder to rely more upon assisted coding options. The very real potential need for new software has not been adequately evaluated in terms of availability (none currently exist for ICD-10) or cost and affordability for physician practices.

Regardless of their coding aptitude, proficiency and expertise, professional coders will be constrained by the specificity of physician documentation. Because professional coders are frequently asked to provide physician documentation education, additional lost production time to allow for this task needs to be fully evaluated and assessed.

**RECOMMENDATION 15:** We recommend that HHS formally consult with the following coding certification organizations to address this important issue: American College of Medical Coding Specialists (ACMCS); American Academy of Professional Coders (AAPC); Radiology Coding Certification Board (RCCB); as well as AHIMA.

#### **E. Coder Certification**

**COMMENT 16:** There are currently a number of professional coding certifications. All include diagnosis coding knowledge. The implementation of a completely new coding system will necessitate all currently certified coders to re-certify or have a recognized methodology to demonstrate comparable expertise under ICD-10. Obviously, this also requires new certification tests, at a significant cost to the industry and to the professional coder.

Because coders will be required to know and retain expertise in ICD-9, as well as ICD-10, for an undetermined period of time, additional costs and support of dual coding systems will be necessary and expensive. We do not believe the HHS estimates adequately address these requirements.

Our earlier reference to the AHA's Coding Clinic was based on its esteemed position as the authoritative source for ICD-9 CM coding knowledge. We believe that implementation of ICD-10 will require that the Coding Clinic information be rewritten in its entirety – at a cost that we believe HHS has not recognized. In addition, the AHA's work will have to be completed and fully vetted two or more years in advance of the ICD-10 “live” date in order for coders, providers, insurers, auditors, compliance officers and trainers to study the new Coding Clinic. Each will then have to practice their skills, prepare and present training programs to their peers, employers and constituents and establish monitoring and audit criteria. All of this will, naturally, impact the various coding certification programs, as well.

**RECOMMENDATION 16:** HBMA recommends that HHS and the AHA evaluate the impact of ICD-10 on the Coding Clinic and issue a jointly prepared evaluation and plan for this important aspect of any transition to ICD-10.

#### **F. Facility Coding**

**COMMENT 17:** The planned implementation of ICD-10-PCS in the facility setting adds several additional layers of complexity to the transition. As described above, current physician documentation does not routinely include technology, sequela specific information, or the specificity designated in the PCS codes. We do not believe the HHS estimates include any plans or cost estimates for the physician education required for the transition to a second completely new and different code set.

Another area of concern is facilities' use of PCS, while professional services continue to be coded using CPT nomenclature, and how or whether correct and appropriate comparisons can be made between physician and facility coding. CMS has promoted the transition to the MAC model as a way to use the CWF to identify discrepancies, potential double billing, and other payment and compliance concerns. HBMA does not believe HHS has adequately investigated the operational issues of using two procedural coding systems for the same services.

The transition from LMRP to LCD did not resolve divergent coverage interpretations and coverage policies. Currently, this creates situations where the facility charges are covered under the FI LCD but denied as “not medically necessary” under the Carrier LCD. The confusion this creates for the patient and the frustration for the provider has the potential to be compounded when the coding systems used to report services have no relationship to each other. We are

concerned that improper denials or payment delays may result from use of two different versions of procedural/service coding.

**RECOMMENDATION 17:** We strongly recommend that HHS conduct a separate study of the hospital and physician practice operational and technological impact, the payment and reimbursement effects and overall costs to both constituencies associated with the implementation of ICD-10 PCS by hospitals.

## **VI. CROSSWALKS**

### **A. ICD-9 CM to ICD-10**

**COMMENT 18:** We concur with HHS that some codes remain similar from ICD-9 to ICD-10 and that the organizational framework is improved. However, no 1:1 crosswalk is possible because the current code may be completely replaced by a single code or multiple codes. The fact that the “logic,” detail, specificity and meaning of characters is new likely makes any automated crosswalk unrealistic. As discussed above, physician offices will not develop or use multi-page check-off forms or superbills to accommodate the expanded code choices and detail.

Because many billing software systems, automated coding software products and electronic health records have already developed diagnosis-to-CPT links or edits, the time and expense required to develop and implement the ICD-10 code sets will be significant. This process is not limited to simply “loading” new information as all look-up tables, edits, links and other billing operational and compliance tools will require revision or the development of new programming. And, the need for and ability to run dual coding systems for the foreseeable future is of great concern. We do not believe HHS has adequately evaluated the time, expense and operational complexities in the physician and non-institutional provider environments.

**RECOMMENDATION 18:** HBMA recommends that HHS further study the transitional requirements of crosswalks between ICD-9 CM and ICD-10.

### **B. ICD-10 to ICD-9 CM**

**COMMENT 19:** Just as there is no 1:1 crosswalk from ICD-9 CM to ICD-10, there is no way to work in reverse, should the need arise due to payer requirements. HBMA is concerned that HHS has not fully evaluated the magnitude of the potential problems when all historical

patient diagnoses are replaced by new code sets. The ability for payers, physicians and patients to follow the continuum of care will be more complex. The fact that diagnosis codes are used for an infinite number of reimbursement determinations by thousands of payers has the potential for additional payment disruptions and practice expense. For example, many commercial payers, as well as Medicare replacement products, rely upon pre-authorizations. The diagnosis code preauthorized may be completely different by the time the patient has the examination or service.

**RECOMMENDATION 19:** HBMA recommends a staged implementation that includes verification of successful testing at specific times to minimize the disruptions to physician practices, patient care and cash flow.

## **VII. CMS/MEDICARE**

### **A. PQRI**

**COMMENT 20:** Every PQRI measure will require revision with the associated system programming and testing, CMS data base updates, PQRI measure worksheet revisions and physician notification and education. Because the proposed ICD-10 implementation date will fall within a reporting period, assuming PQRI is funded in the same way at that time, payers will need to be able to combine policies and process claims, based on date of service, to determine correct physician reimbursement. HBMA does not believe HHS has evaluated the cost and time required for this implementation.

**RECOMMENDATION 20:** We recommend that HHS require that CMS study the effects and costs of IDC-10 implementation on the PQRI program and publish their findings at least 24 months before the planned ICD-10 commencement date.

### **B. LCD**

**COMMENT 21:** The transition to ICD-10 will require every LCD to be revised, with the associated system programming and testing, CMS database updates, physician notification and education and the required notification and comment period. HBMA does not believe CMS has evaluated the impact, cost or time required for this implementation.

### C. NCD

**COMMENT 22:** Some NCD policies will require revision, ie. Pathology services, PET scans, covered screening examinations, etc., with the associated system programming and testing, CMS data base updates, physician notification and education and the required notification and comment period. HBMA does not believe CMS has evaluated the impact, cost or time required for this implementation.

### **SUMMARY**

HBMA member billing companies support advancements that improve patient care, lowering the cost of health care delivery, increasing administrative efficiency, automation, innovation, contributing to clinical research and data collection and other forms of progress. We believe that there is some evidence that moving to ANSI 5010 transaction standards may contribute to these goals. However, there is scant evidence that the transition to ICD-10 will contribute, in any meaningful way, to any but the last of these goals.

**We do not categorically oppose transition to ICD-10, but believe that to be successful, there must first be a completely successful and demonstrated, fully operational ANSI 5010 transaction system in place, which we recommend be given at least 24 months from the publication of HHS Final 5010 Rules. Subsequent to a successful ANSI 5010 deployment, the ICD-10 transition should be given a full 36 months for implementation.**

We also believe that HHS or CMS should explore ways to provide financial support or other economic incentives, grants, payment supplements or other funding methods to provide to healthcare organizations and practices to offset the costs of this unfunded mandate. If you have any questions or need additional information about HBMA's comments, please do not hesitate to contact Bill Finerfrock (202-544-1880) or Brad Lund (877-640-4262).

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'K Goodin', with a stylized flourish at the end.

Kenneth Goodin CHBME  
President