DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

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JAMES L. MADARA, MD
EXECUTIVE VICE PRESIDENT, CEO

James L. Madara, MD
Chief Executive Officer & Executive Vice President
American Medical Association
25 Massachusetts Avenue, NW, Suite 600
Washington, DC 20001

Dear Dr. Madara:

Thank you for your letter regarding the implementation of the International Classification of Diseases, 10th Revision, Clinical Modification and the International Classification of Diseases, 10th Revision, Procedure Coding System (collectively, ICD-10). We agree that a successful ICD-10 implementation is a top priority and appreciate the opportunity to receive your feedback.

The Centers for Medicare & Medicaid Services (CMS) is taking a comprehensive approach to preparedness and testing to ensure that CMS as well as providers and other stakeholders are ready. As leaders in the health care industry, we ask you to help providers ramp up their efforts to prepare for ICD-10. There is still time to prepare and help is available. CMS has collaborated with physicians and other industry stakeholders to create tailored training, resources, and tools specifically to help physicians and their staff prepare for the ICD-10 transition.

Our ICD-10 work at CMS is part of a larger effort. CMS hosts national weekly implementation meetings with provider groups, industry stakeholders, clearinghouses, vendors, and commercial payers. We have called for the health care industry at large to align its outreach efforts to help physicians make the transition to ICD-10. We have gained the support of many groups to help physicians, including our most recent effort that garnered the assistance of 1000 supporters with a reach to 477,000 social media followers to reemphasize our ICD-10 commitment and call to action. We have expanded our free on-the-ground trainings across the country, national provider calls and webinars, training videos, testing, and other events conducted with partners, and tools and resources like the CMS website and Road to 10 tool.

The Road to 10 tool was created in collaboration with small physician practices and features five simple steps that physician should take to prepare with guided milestones and action plans. The tool highlights provider-inspired tip sheets, fact sheets, and checklists and free local training. Road to 10 also features interactive clinical scenarios and case studies, coding and clinical documentation tips for both primary care and specialty training. CMS has also released provider training videos that offer helpful ICD-10 implementation tips with some providing free continuing medical education and continuing education credits. With extensive input from provider and industry stakeholders, CMS continues to develop new implementation and educational resources to help everyone successfully transition to ICD-10.

We work closely with all physicians and stakeholders to provide pre- and post- implementation support. For example, CMS is adding additional call center support through its Medicare Administrative Contractors to help physicians before and after the transition date. Additionally, CMS, the Workgroup for Electronic Data Interchange (WEDI), the AMA, the American Hospital Association, and other industry leaders and partners, launched the "ICD-10 Implementation Success Initiative." The ICD-10 Industry Success Initiative is comprised of several elements, including a searchable database of ICD-10 issues which is open to the public for submission. WEDI, CMS, and stakeholders help to triage issues and provide valuable information and resources to help providers and health care organizations with pre- and post-implementation questions. This public and private initiative is a valuable resource for questions and best practices as we move toward the ICD-10 transition and beyond.

Testing

CMS's Medicare Fee-For-Service (FFS) claims processing systems are ready for the compliance date of October 1, 2015. We will continue to test our systems with each quarterly release to ensure ICD-10 readiness.

CMS is conducting an unprecedented and additional level of testing to prepare providers for ICD-10 and has instructed its Medicare Administrative Contractors (MACs) to reconfigure test environments specifically for ICD-10 to help support provider readiness. We have conducted end-to-end testing with providers in January and April and are reopening our July testing window to allow additional time for physicians to participate. The July testing will be conducted on July 20-24, 2015, and physicians are encouraged to sign up from May 11-22, 2015. ICD-10 acknowledgement testing is also available to all physicians through September 30, 2015. CMS is also highlighting acknowledgement testing during the week of June 1-5, 2015, to bring greater awareness to the provider community.

CMS also recommends that the provider community leverage the variety of Beta versions of its software that include ICD-10 codes, as well as national coverage determination and local coverage determination code crosswalks. These testing tools are available for download from the CMS website and include:

- National Coverage Determinations (NCD) converted from ICD-9 to ICD-10.
- Medicare Severity-Diagnosis Related Groups (MS-DRG) converted from the current ICD-9 version to an ICD-10-CM.
    - Versions of the current ICD-10-CM MS-DRG Grouper, Medicare Code Editor (MCE), and MS-DRG Definitions Manual are available.
- A pilot version of the October 2014 Integrated Outpatient Code Editor (IOCE) utilizing ICD-10-CM.
- Local coverage determinations (LCD) consolidated in the LCD database.

General Equivalence Mapping (GEM) tools are available to convert data from ICD-9-CM to ICD-10-CM and ICD-10-PCS and vice versa. The GEMs are also known as crosswalks as they provide important information linking codes of one system with codes in the other system.

However, the GEMs are not a substitute for learning how to use ICD-10-CM and ICD-10-PCS and will not be used to code patient encounters. Providers' coding staff should continue to assign codes describing the patients' encounters from the ICD-10-CM and ICD-10-PCS code books or encoder systems. In addition, free billing software (internet connectivity is required) is available for download from each MAC website. CMS encourages Medicare FFS providers and submitters to utilize these tools as they test the ICD-10 readiness of their own systems.

The Medicare FFS program is holding multiple testing sessions with providers and has been pleased to accommodate all interested volunteers thus far. Since testers are permitted to test with up to five National Provider Identifiers, the 2,550 testers are representative of a higher number and broader range of providers. Of the test claims received in the January testing from the approximately 1,400 NPIs registered to test, 56 percent were professional, 38 percent were institutional, and 6 percent were supplier. The following provider types participated in the testing:

Type	**% of Testers**	**Type**	**% of Testers**
Ambulance	1.8	Hospital – Psychiatric	2.2
Ambulatory Surgical Center	1.0	Hospital – Inpatient Rehabilitation	2.5
Behavioral Health Provider	0.6	Imaging/Testing	0.5
Clinic/Group	0.3	Lab	2.2
Durable Medical Equipment Supplier	11.5	Non-MD	3.6
End Stage Renal Disease Provider	1.9	Other	3.1
Federally Qualified Health Center	0.3	Primary Care	4.9
Home Health Agency	0.9	Rural Health Clinic	1.0
Hospice	1.0	Skilled Nursing Facility	3.1
Hospital - All Others	23.4	Specialists	31.3
Hospital – Critical Access Hospital	2.9		
Total			**100**

Overall, CMS end-to-end test results have been very positive, and we will continue to release results at the conclusion of each test period. CMS continues to evaluate the results from the January end-to-end testing period and will update the testing results document posted to the CMS website as new information becomes available (http://www.cms.gov/Medicare/Coding/ICD10/Downloads/2015-Jan-End-to-End-Testing.pdf).

There is one point we would like to clarify from our January testing results. Most of the rejects experienced were directly related to problems in the testers' set up of the test claims. Examples of these problems include: test claims that contained a National Provider Identifier, Health Insurance Claim Number, or Submitter Identifier that did not match the ones submitted on the testing registration, dates of service outside the range valid for testing, invalid procedure codes, and invalid places of service. These issues are unrelated to the submission of the diagnosis on the test claim, but resulted in the test claim being rejected. The low reject rate of 3 percent for ICD-10 related issues was a very positive finding.

While the overall reject rate was 19 percent, given the reasons for a large portion of the rejects explained above, we believe it is more appropriate to extrapolate the total number of rejects into anticipated rejects when ICD-10 is implemented by looking at the 3 percent reject rate specific to ICD-10. CMS and its MACs continue to conduct provider education to mitigate these and other types of errors in preparation for upcoming testing periods. In addition, we encourage providers who submit claims using clearinghouses or billing agents to work closely with these organizations to be certain their test claims are set up properly. CMS also encourages providers to engage in testing with other payers with which they do business.

Although CMS has received good feedback from testers, it is important to note that CMS is not in a position to report on whether expected results were achieved by the end-to-end testers. Per standard practice, the testers developed specific test cases and scenarios for their individual evaluation and review.

Quality Measurement

CMS appreciates the AMA's concerns regarding the denominators and rates for ICD-10 specified measures. We think that the current measure specifications address the transition from ICD-9 to ICD-10, and we will continue to monitor reported quality measure results. In addition, we will continue to monitor the ICD-10 transition for any effect on the quality and cost measures and benchmarks used under the Value Modifier Program.

The 2015 Physician Quality Reporting System (PQRS) Measure Specification documents (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html) outline that ICD-9-CM codes will be utilized from January 1, 2015, to September 30, 2015, and ICD-10-CM codes will be utilized from October 1, 2015, to December 31, 2015. ICD-10-CM codes will count towards satisfactorily reporting the measures under the PQRS in the 2015 program year. Therefore, there will be 12 months of reported measure data included in the PQRS analysis. In 2014, the ICD-10-CM codes were included in measure specifications so that eligible professionals could begin preparation for implementation in 2015 PQRS.

Risk Mitigation

Contingency Plans - Advanced Payment Policy & Software Upgrades

CMS remains committed to the continuity of care for our beneficiaries and timely payments to Medicare providers, while we continue to safeguard trust fund dollars. CMS would consider the application of current published regulations, 42 CFR § 421.214(g), which provides that CMS may determine circumstances that warrant the issuance of advance payments to all affected suppliers furnishing Part B services without requiring specific requests from the physician/supplier. This authority applies only to the situation where CMS systems would be unable to process valid Part B claims that contain ICD-10 codes beginning October 1, 2015. If CMS were to rely upon this authority, then no further action would be needed by the physician/supplier.

Additionally, CMS has the following options for providers who are unable to submit claims with ICD-10 diagnosis codes due to problems with the provider's system. Each of these requires that the physician be able to code in ICD-10:

- Free billing software that can be downloaded at any time from every MAC;
- In about half of the MAC jurisdictions, claims submission functionality on the MAC's provider internet portal; and
- Submitting paper claims, if the requirements of section 1862(h) are met.

Specificity of Codes and Audit Plans

CMS has issued guidance on the use of unspecified codes for Medicare FFS claims. In both ICD-9-CM and ICD-10-CM, signs/symptoms and unspecified codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. Each health care encounter should be coded to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, unspecified codes should be reported when such codes most accurately reflect what is known.

All the Medicare claims audit programs will use the same approach under ICD-10 as is used under ICD-9. Physicians, like all providers, are expected to code correctly and have sufficient documentation to support the codes selected. For example, if a physician is treating a patient for diabetes, there should be an ICD-10 code on the claim for diabetes. The level of specificity of the diabetes code selected will not change the coverage and payment of services in most cases.

Thank you again for sharing your recommendations and we welcome your input and feedback on additional ways to help physicians make a successful transition to ICD-10. CMS is committed to moving forward on the transition to ICD-10. We would be pleased to meet with you to provide additional guidance and to discuss specific implementation issues. Please share this response with the cosigners of your letter.

Sincerely,

Andrew M. Slavitt
Acting Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Administrator
Centers for Medicare & Medicaid Services
Washington, DC 20201-0001

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Prepared by: Mari Savickis

March 4, 2015

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Andrew Slavitt
Acting Administrator
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Department of Health and Human Services
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Washington, DC 20201

Dear Acting Administrator Slavitt:

The undersigned organizations are writing to you concerning the agency's implementation plans for moving to ICD-10, a code set named under the Health Insurance Portability and Accountability Act (HIPAA) that will be required for use by physicians and others starting October 1, 2015. The transition to ICD-10 represents one of the largest technical, operational, and business implementations in the health care industry in the past several decades. Given the profound impact this will have on physicians, we have a number of concerns that do not appear to be addressed by the Centers for Medicare & Medicaid Services' (CMS) current transition plan.

Testing

We appreciate the training, educational tools, and other efforts by CMS to prepare physicians and other health care entities for the ICD-10 transition. Despite these efforts, there still remains a lack of industry-wide, thorough end-to-end testing of ICD-10 in administrative transactions.

CMS conducted acknowledgement testing of claims for one week in March and November 2014 and additional weeks are planned in March and June 2015. Acknowledgement testing, however, is limited in that it only tests that the claim will be initially accepted through the claims processing system. It provides no information about if and how the claim will process completely, ensuring payment to physicians.

Results of this acknowledgement testing were also limited, with acceptance rates ranging from 89 percent to 76 percent. In comparison, the normal acceptance rate for Medicare claims is 95 – 98 percent. Given that Medicare processes 4.4 million claims per day, even a small change in this acceptance rate will have an enormous impact on the system and payment to physicians.

It would help for CMS to explain in detail the errors that were encountered and what steps need to be taken to correct these problems.

Table 1. Medicare Acknowledgement Testing Results

	March	**November**
Total Number of Claims Tested	127,000	13,700
Participants (A/B providers) Percent of overall A/B providers[i]	2,600 .16%	500 .03%
Percentage of Claims Accepted Percent of overall Medicare claims submitted annually[ii]	89% .01%	76% .001%

i = According to CMS' Fast Fact, November 2014, there are 1,618,419 Medicare Part A&B providers

ii = According to CMS' Fast Fact, November 2014, there are 1,213,368,119 claims processed annually

We appreciate that CMS agreed to conduct more robust end-to-end testing in which the claim will be accepted, processed, and a remittance advice generated. We are worried, however, that the testing may not provide an accurate depiction of provider readiness given the small sample size. CMS is only planning on testing with 850 claims submitters per testing week for a total of 2,550 testers. This represents a very small fraction of all Medicare providers and an even smaller universe of claims submitted each year. In addition, because the testing participants are volunteers, it is possible that those most confident of their preparation self-selected into the testing program—so that the numbers of successful efforts are not representative.

In addition, the first week of end-to-end testing was completed the last week of January 2015 and the results of the testing were just released. The data from this testing show only a broad overview of the number of claims received (14,929), number of claims accepted (12,149), acceptance rate (81%), and partial information about the reasons and percentages of rejected claims. Again, the acceptance rate was still well below average, and we continue to be concerned about the limited scale of testing being performed. **Accordingly, we strongly urge CMS to release more detailed end-to-end testing results broken out by the type and size of providers who tested, number of claims tested by each submitter, percentage of claims successfully processed, and specific details about problems encountered.**

Quality Measurement

In addition to claim processing, questions remain about the ability to correctly collect and calculate quality data during and after the transition to ICD-10. While CMS has stated that

quality measures have been specified for ICD-10, we foresee unintended consequences for measure denominators and measure rates due to potentially conflicting timelines. ICD-10 is scheduled to begin on October 1, 2015, but the Physician Quality Reporting System (PQRS) and Meaningful Use (MU) quality reporting periods are based on the calendar year (January 1-December 31, 2015). Many of the MU and PQRS measures capture encounters pre and post visit and will straddle the October 1 date, requiring that physicians report ICD-9 for the first segment and ICD-10 for the final portion. CMS has not discussed how it plans to address and correctly tabulate quality performance reporting metrics after the transition to ICD-10.

We are also concerned about the effects of ICD-10 on Value Based Modifier (VBM) measures, as measure calculations and associated costs will vary depending upon the utilization of ICD-9 or ICD-10. In part, the VBM formula compares how providers perform from year-to-year. Accordingly, transitioning the VBM program to the more granular ICD-10 system could significantly alter how measures are scored between the baseline and performance periods. Similarly, commercial payers also have quality reporting systems that impact physician reimbursement and ratings and are likely to be affected by the code set change.

In addition to our concerns noted above regarding testing, Medicare's end-to-end testing is not expected to evaluate the impact on quality measurement or Medicare's ability to properly calculate measures. **We strongly urge CMS to: 1) provide details on how it plans to ensure that the measure calculations for these programs are not adversely impacted by the transition to ICD-10; and 2) ensure cross-walks do not attribute increased costs to a physician's VBM score when switching to ICD-10. Any changes in measure specifications from ICD-9 to ICD-10 should demonstrate stability and be budget neutral during the transition.**

Risk Mitigation

Contingency Plans and Advance Payments

Previous HIPAA mandates—such as the National Provider Identifier (NPI) and the upgrade to Version 5010 transactions— resulted in significant claims processing disruptions that caused physicians to go unpaid for weeks and sometimes months. These implementations were less complex than ICD-10 and still resulted in significant disruptions.

By CMS' own analysis, one of the most significant risks to moving to ICD-10 is the likelihood for claims processing and cash flow interruptions. It is therefore vitally important that CMS is prepared with extensive contingency plans in the event that these feared disruptions occur.

In particular, we have asked CMS to help mitigate these risks by granting "advance payments" (which are nothing more than reimbursement outside of the normal claims processing system for services already rendered, such as paper checks) to physicians experiencing a dire financial hardship as a result of the change to ICD-10, particularly if the issue originates on Medicare's end. We appreciate the Administration's indication to use advance payments; however, we urge CMS to publicize and finalize this policy.

Software Upgrades

Physicians who bill Medicare are required to use a certified electronic health record (EHR); otherwise, they face a financial penalty under the MU program. The Version 2014 certified software is required to accommodate ICD-10 codes; yet, many EHR vendors were behind in delivering upgrades to physicians in 2014 to meet the MU program. There is no data that indicates when vendors will be ready to deliver the ICD-10 upgrades and what help will be available for physicians whose vendors decided not to certify to 2014. **We strongly urge CMS, together with the Office of the National Coordinator for Health Information Technology (ONC), to study this issue and make information about vendor readiness available.**

Specificity of Codes and Audit Plans

There continue to be questions in the physician community concerning the specificity of codes required for inclusion on Medicare claims following the transition to ICD-10. CMS officials have stated that, absent indications of potential fraud or intent to purposefully bill incorrectly, CMS will not instruct its contractors to audit claims to verify that the most appropriate ICD-10 code was used. There is also general concern about how physicians will be audited as they learn to use the new code set. **We urge CMS to: 1) confirm and broadly educate stakeholders and contractors that claims will not be audited simply for code specificity; and 2) to instruct contractors that they are prohibited from engaging in audits that are only predicated on code specificity.**

Conclusion

By itself, the implementation of ICD-10 is a massive undertaking. The undersigned organizations remain gravely concerned that many aspects of this undertaking have not been fully assessed and that contingency plans may be inadequate if serious disruptions occur on or after October 1. Furthermore, physicians are being asked to assume this significant change at the same time they are being required to adopt new technology, re-engineer workflow, and reform the way they deliver care—all of which are challenging their ability to care for patients and make

investments to improve quality. We appreciate the opportunity to offer this perspective and these recommendations and look forward to further dialogue on this issue.

Sincerely,

American Medical Association
American Academy of Allergy, Asthma & Immunology
American Academy of Dermatology
American Academy of Emergency Medicine
American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology— Head and Neck Surgery
American Association of Clinical Endocrinologists
American Association of Hip and Knee Surgeons
American Association of Neurological Surgeons
American Association of Neuromuscular & Electrodiagnostic Medicine
American Association of Orthopaedic Surgeons
American Clinical Neurophysiology Society
American College of Cardiology
American College of Chest Physicians
American College of Mohs Surgery
American College of Occupational and Environmental Medicine
American College of Osteopathic Internists
American College of Osteopathic Surgeons
American College of Physicians
American College of Radiology
American College of Rheumatology
American College of Surgeons
American Congress of Obstetricians and Gynecologists
American Geriatrics Society
American Orthopaedic Foot & Ankle Society
American Osteopathic Association
American Society for Clinical Pathology
American Society for Dermatologic Surgery Association
American Society for Gastrointestinal Endoscopy
American Society for Radiation Oncology

American Society for Surgery of the Hand
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Cytopathology
American Society of Dermatopathology
American Society of Hematology
American Society of Interventional Pain Physicians
American Society of Retina Specialist
American Urological Association
College of American Pathologists
Congress of Neurological Surgeons
Heart Rhythm Society
International Society for the Advancement of Spine Surgery
Medical Group Management Association
National Association of Medical Examiners
North American Spine Society
Renal Physicians Association
Society of Interventional Radiology
Society of Thoracic Surgeons

Medical Association of the State of Alabama
Arizona Medical Association
Arkansas Medical Society
California Medical Association
Colorado Medical Society
Connecticut State Medical Society
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association Inc
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association

MedChi, The Maryland State Medical Society
Massachusetts Medical Society
Michigan State Medical Society
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Rhode Island Medical Society
South Carolina Medical Association
South Dakota State Medical Association
Texas Medical Association
Utah Medical Association
Vermont Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
Wisconsin Medical Society