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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM
February 9, 2015

To: Committee on Energy and Commerce Democratic Members and Staff

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Re: Hearing on "Examining ICD-10 Implementation"

On Wednesday, February 11, 2015 at 10:15 am in 2322 Rayburn House Office Building, the Subcommittee on Health of the Committee on Energy and Commerce will hold a hearing entitled "Examining ICD-10 Implementation."

I. Background

The International Classification of Diseases (ICD) is a set of codes developed by the World Health Organization (WHO) used by providers to classify patients' signs and symptoms, diseases, and diagnoses.

The United States (US) currently uses the 9th revision of the ICD (ICD-9), which has been in use since 1979). The WHO endorsed the 10th revision (ICD-10) in 1990. Congress included a requirement that US providers transition ICD-10 in the Health Insurance Portability Accountability Act (HIPAA) of 1996. After a series of delays, the US transition to ICD-10 will occur on October 1, 2015.

ICD-10 has a more expansive set of codes that allow providers to more accurately classify patients. ICD-10 also has codes for new diagnoses that did not exist when ICD-9 was developed. Continuing to use ICD-9 reduces the quality of health care data that US health care providers currently collects. Transitioning to ICD-10 will allow for greater specificity in diagnoses, which will lead to more accurate billing, quality reporting and measurement and greater fraud and abuse prevention. The US will be the last industrialized nation to switch to ICD-10.

ICD-10 has two parts: ICD-10-CM *diagnosis coding*, which will be used in in all health care settings; and ICD-10-PCS *inpatient procedure coding*, which will be used in just hospital settings. All providers that are covered by HIPAA will have to comply with ICD codes—not just those who take Medicare or Medicaid. Insurers also use ICD to pay for services and procedures.

ICD-10 is used just for diagnoses and inpatient procedures. The Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) will continue to be used to report services and procedures in outpatient and office settings.

i. Covered Entities

Virtually all actors in our health care system will be affected by the transition to ICD-10 codes.

- Providers (doctors, nurses, PAs, etc) and coding staff will use ICD-10 codes to classify diagnoses and procedures in order to submit claims to insurers for reimbursement. The medical community has mixed reactions to the transition: some have spent time and resources and are ready to go and other groups say they are not ready.

- Both public and private insurers will need to transition to ICD-10 in order to accept claims from providers. Insurers have spent the last few years getting ready for this transition, which is why the America's Health Insurance Plans (AHIP) opposes any further delay.

- Health IT vendors will have upgraded software. One of the reasons that these vendors have adamantly opposed further delay is that they have invested significant resources in upgrading software for their clients, and most of them are ready to go forward.

- Billing services and clearinghouses will also need to transition to ICD-10 as they act to help providers and insurers process claims. These groups are decidedly ready for the transition.

ii. History of Delay

ICD-9 was implemented nearly 40 years ago in the US; never before has the same version of ICD been used for this length of time. The US transition to ICD-10 has been delayed twice.

Initially, HHS regulations mandated use of ICD-10 codes by October 10, 2013. However, in September of 2012, CMS pushed back the implementation date to October 2014 to give the covered entities more time to prepare. The most recent delay was included in the March 2014 SGR patch, the Protecting Access to Medicare Act of 2014. A provision was included that prohibited the Secretary from requiring ICD-10 adoption before October 2015. This delay was a last minute addition. Seeing that the provision was attached to the "must-pass" SGR package, it passed. Shortly after the passage of the March 2014 legislation, the Centers for Medicare and Medicaid Services (CMS) announced that the new compliance date for the use of ICD-10 will be on October 1, 2015.

Each delay has been costly for the health care industry. In order to switch to ICD-10, covered entities had to invest time and resources to train their workers and upgrade their systems. The delays set them back for that time and money. In 2014, the American Health Information Management Association (AHIMA) estimated that the delay of ICD-10 in the SGR patch would cost the health care sector an additional $1 billion to $6.6 billion, on top of the costs already incurred from the previous one-year delay.

iii. Stakeholder Input

Some physicians groups have been vocally advocating for an additional delay to ICD-10 implementation. These groups claim that the transition is too costly and that they lack needed transition resources. Last year, the American Medical Association (AMA) released a study which estimated that high transitioning costs would be prohibitive for small practices. However, the AMA still urges physicians to prepare for the upcoming compliance date of October 1, 2015.[1]

In fact, some groups have already suggested the US forgo ICD-10 altogether and wait for ICD-11, due out in 2017. It is important to note that waiting for ICD-11 in 2017 does not mean that the US will upgrade its outdated coding system in 2017; it will be years before the health care system is prepared to implement it. ICD-10 was endorsed by the WHO in 1990, and more than 20 years later, physicians still claim they aren't ready. Further, the difference between ICD-9 and ICD-11 is far greater than the difference between ICD-9 and ICD-10. A transition straight to ICD-11 would be even more dramatic for the health care system.

There is a broad-based coalition that advocates against any further delay (the Coalition for ICD-10). It includes AdvaMed, American Hospital Association (AHA), AHIP, and many other physician groups and industry leaders. These groups do not want to continue to delay implementation, as they have already expended significant resources upgrading their computer systems and training staff. They argue that another delay or skipping over ICD-10 would be a loss of billions of dollars that they have already invested or budgeted. Many of the largest health care systems had already spent considerable resources to meet the October 1, 2014 deadline, and some spent resources preparing for the initial deadline of October 1, 2013. AHA released a survey in 2013, showing that nearly 95 percent of its member hospitals were moderately to very confident of meeting the October 1, 2014.

CMS is ready for the transition. It has completed end-to-end ICD-10 testing with state Medicaid agencies and Medicare fee-for-service (FFS) contractors to ensure they are able to transmit the new classifications. CMS completed a successful test last year, accepting submission of over 127,000 claims using ICD-10 codes. The agency has a technical assistance web page, including resources designed to help providers, payers, vendors, and non-covered entities with the transition to ICD-10, and is doing specific, targeted outreach to help small

[1] American Medical Association, *ICD-10 Code Set to Replace ICD-9* (online at http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act/transaction-code-set-standards/icd10-code-set.page).

practices. CMS has built a "Road to 10" website (http://www.roadto10.org) with input from small practice physicians, which is a free tool to help practices make the switch.

iv. GAO Report on ICD-10 Implementation

On February 6, 2015, the Government Accountability Office (GAO) released a report entitled "International Classification of Diseases: CMS's Efforts to Prepare for the New Version of the Disease and Procedure Codes". The report highlights page is attached to this memo. GAO's analysis includes both the status of CMS' preparation efforts and a summary of stakeholder concerns and CMS responses.

The report outlines the many outreach and assistance activities that CMS has undergone to help those entities, including providers, health plans, and Medicaid agencies, that will need to transition to ICD-10. CMS has and continues to do internal testing to ensure that Medicare FFS will be able to process ICD-10 claims. CMS has scheduled end-to-end testing with 2,550 covered entities during 2015.

II. Benefits and costs of ICD-10

RAND did a cost-benefit analysis in 2004, which showed the benefits of transitioning to ICD-10 outweighed the costs.[2] RAND estimated that the cost of transitioning would be between $475 million and $1.5 billion over ten years due to training, productivity losses, and systems changes. RAND additionally estimated, however, that benefits to the industry would be between $700 million and $7.7 billion in cost savings due to more accurate payments, fewer rejected claims, fewer fraudulent claims, better understanding of new procedures, and improved disease management. Additionally, a 2011 HHS analysis estimated the cost of transitioning to ICD-10 codes would be $1.64 billion, including $357 million for staff training, $572 million for losses in productivity, and $713 for system changes. However, HHS's analysis showed savings of more than $87.7 million annually—and as much as $3.95 billion by 2023.

i. Updated, More Specific Classifications

ICD-9 was developed in 1979. There have been great medical breakthroughs since then, and ICD-9 does not have codes for them. For example, laparoscopic surgery did not exist during the development of ICD-9 but now has become fairly common. ICD-10 will increase the number of procedure codes from 4,000 to 72,000, and the number of diagnosis codes from 14,000 to 69,000. Note that physicians will only use the subset of these codes that apply to their practices and patient populations. ICD-10 will include more accurate medical descriptions, varying levels of risk and severity, and symptoms. For example, where ICD-9 would specify "suture of an artery", ICD-10 will specify which artery and the approach used to perform the procedure.

[2] Martin Libicki et al., RAND Corporation, *The Costs and Benefits of Moving to the ICD-10 Code Sets* (Mar. 2004) (online at http://www.rand.org/content/dam/rand/pubs/technical_reports/2004/RAND_TR132.pdf).

ii. Discourages Waste, Fraud, Abuse

ICD-9's less accurate, broader codes often make it difficult to classify exact diagnoses and services. As such, more precise information will improve claims processing. Insurers will reject fewer claims and not have to ask for more information as often. This will save on administrative costs for both providers and insurers.

Additionally, both public and private insurers will better be able to ferret out fraud and abuse. Often when a patient's diagnosis or procedure is somewhere in between two ICD-9 codes, coders will classify patients as the higher severity, which gets a higher reimbursement. With more specific codes, coders will have more degrees of severity to choose from, which will result in more accurate payments.

iii. Encourages Better Patient Care/Leads to Better Outcomes

The Affordable Care Act (ACA) included a number of provisions to help our health care system move towards paying for value, not volume. There is still much work to do in this regard, but transitioning to ICD-10 will help as providers are increasingly held accountable for patient outcomes. Specifically, ICD-10 includes a larger number of "external causes", which can help providers improve their patient safety efforts and reduce their hospital acquired conditions and preventable readmission rates.

For example, the ACA authorized CMS to test new payment models having the potential to improve quality and constrain health care cost growth. One such model is the Accountable Care Organization (ACO). An ACO is a group of providers who agree to work together to coordinate the care of a population. Under the Medicare program, the ACO receives a share of any savings achieved if spending for the population managed by the ACO is less than what Medicare projects, so long as the ACO also meets quality standards. As ACOs work to provide better care coordination, more specific ICD-10 codes will help them find solutions. One example of this is a patient who, after leaving the provider's office, does not follow the provider's recommendations for care. ICD-9 only has one code to describe this scenario. Accordingly, it would be more complicated under that scenario for providers to determine what steps to take. ICD-10, on the other hand, would have approximately eight different ways to classify such a patient, so that providers could determine which patterns and what interventions might help.

iv. Better Epidemiological Data

The greater specificity of ICD-10 will help public health officials to better track diseases, public health threats, outbreaks, and potentially, bioterrorism. Additionally, the new codes that describe external circumstances surrounding diagnoses will help public health researchers track how people get sick or hurt and to better prevent these outcomes. ICD-10 will also allow researchers to compare health data across countries.

III. Witnesses

Rich F. Averill
Director of Public Policy
3M Health Information Systems

Sue Bowman
Senior Director, Coding Policy and Compliance
American Health Information Management Association (AHIMA)

Edwin M. Burke, MD
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Kristi A. Matus
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