United States Government Accountability Office

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INTERNATIONAL CLASSIFICATION OF DISEASES

CMS's Efforts to Prepare for the New Version of the Disease and Procedure Codes

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Why GAO Did This Study

In the United States, every claim submitted by health care providers to payers—including Medicare and Medicaid—for reimbursement includes ICD codes. On October 1, 2015, all covered entities will be required to transition to the 10th revision of the codes, requiring entities to develop, test, and implement updated information technology systems. Entities must also train staff in using the new codes, and may need to modify internal business processes. CMS has a role in preparing covered entities for the transition.

GAO was asked to review the transition to ICD-10 codes. GAO (1) evaluated the status of CMS's activities to support covered entities in the transition from ICD-9 to ICD-10 coding; and (2) described stakeholders' most significant concerns and recommendations regarding CMS's activities to prepare covered entities for the ICD-10 transition, and how CMS has addressed those concerns and recommendations. GAO reviewed CMS documentation, interviewed CMS officials, and analyzed information from a non-probability sample of 28 stakeholder organizations representing covered entities and their support vendors, which GAO selected because they participated in meetings CMS held in 2013 or met GAO's other selection criteria.

GAO provided a draft of this report to HHS. HHS concurred with GAO's findings and provided technical comments, which GAO has incorporated, as appropriate.

View GAO-15-255. For more information, contact Vijay A. D'Souza at (202) 512-7114 or dsouzav@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), has undertaken a number of efforts to prepare for the October 1, 2015, transition to the 10th revision of the International Classification of Diseases (ICD-10) codes, which are used for documenting patient medical diagnoses and inpatient medical procedures. CMS has developed educational materials, such as checklists and timelines, for entities covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)—that is, health care providers, clearinghouses, and health plans, which GAO refers to as "payers"—and their support vendors. In addition, CMS has conducted outreach to prepare covered entities for the transition by, for example, holding in-person training for small physician practices in some states. CMS officials have also monitored covered entity and vendor readiness through stakeholder collaboration meetings, focus group testing, and review of surveys conducted by the health care industry. CMS also reported modifying its Medicare systems and policies. For example, CMS documentation states that the agency completed all ICD-10-related changes to its Medicare fee-for-service (FFS) claims processing systems, which reflect the results of internal testing. At this time, it is not known what, if any, changes might be necessary based upon the agency's ongoing external testing activities. CMS has also provided technical assistance to Medicaid agencies and monitored their readiness for the transition. For example, all Medicaid agencies reported that they would be able to perform all of the activities that CMS has identified as critical by the transition deadline; however, as of November 2014, not all agencies have started to test their systems' abilities to accept and adjudicate claims containing ICD-10 codes.

Stakeholder organizations identified several areas of concern about the ICD-10 transition and made several recommendations, which CMS has taken steps to address. For example, stakeholders expressed concerns that CMS's testing activities have not been comprehensive. In addition, while all 28 stakeholders GAO contacted indicated that CMS's educational materials have been helpful to covered entities, stakeholders were concerned about the extent to which those entities were aware of and using those materials. In response, CMS officials said that the agency has scheduled end-to-end testing with 2,550 covered entities during three weeks in 2015 (in January, April, and July), and has promoted awareness of its educational materials by, for example, partnering with payers, providers, and others to direct users to available CMS and industry educational resources. Stakeholders also recommended that CMS expand its in-person training and develop additional specialty-specific materials. CMS officials said the agency has added in-person training in additional states with plans to also offer more video trainings, and planned to develop additional specialty-specific materials. Additionally, stakeholders recommended that CMS do more to engage covered entities through non-electronic methods and to make its Medicare FFS contingency plans public. CMS officials indicated that the agency employs various methods to engage covered entities—including bi-weekly stakeholder collaboration meetings and print advertisements—and also conducted a direct mail pilot project to primary care practices in four states, and plans to expand the pilot. CMS officials also indicated the information in the agency's contingency plans that are relevant to providers is currently publicly available.

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Abbreviations

AHA	American Hospital Association
AHIMA	American Health Information Management Association
ICD	International Classification of Diseases
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology®
FFS	fee-for-service
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
MAC	Medicare Administrative Contractor
MLN	Medicare Learning Network®
MS-DRG	Medicare-Severity Diagnosis-Related Group
REC	Regional Extension Center
WEDI	Workgroup for Electronic Data Interchange

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

January 28, 2015

The Honorable Orrin G. Hatch
Chairman
The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

In the United States—where health care spending was $2.8 trillion in 2012—every claim submitted by health care providers to health care payers for reimbursement includes International Classification of Diseases (ICD) codes.[1] ICD codes are the standard code set used in the United States, including in the Medicare and Medicaid programs, for documenting patient medical diagnoses and inpatient medical procedures.[2] The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), enforces the use of ICD codes by entities covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)—that is, health care providers, health care clearinghouses, and health plans, which we refer to as "payers" in this report.[3] On October 1, 2015, all HIPAA-covered entities

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[1]Centers for Medicare & Medicaid Services, *National Health Expenditures 2012 Highlights*, accessed October 24, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf.

[2]Medicare is the federal health care program for elderly and disabled individuals. Medicaid is the joint federal-state health care financing program for certain categories of low-income individuals. In 2012, federal and state spending for both programs was $994 billion. To obtain Medicare benefits, beneficiaries may opt to enroll in Medicare's traditional fee-for-service program or in a private Medicare Advantage plan, which is administered by a Managed Care Organization. Whereas Medicare pays fee-for-service providers who submit claims for reimbursement after services have been provided, Medicare pays Medicare Advantage Organizations a fixed monthly amount per enrollee to cover all the services enrollees use.

[3]Covered entities include health care providers that transmit any information in an electronic form in connection with a transaction for which HHS has adopted a HIPAA standard; health plans that include public payers, like Medicare and Medicaid, as well as private insurers; and health care clearinghouses. Pub. L. No. 104-191, § 262, 110 Stat. 1936, 2021, 2023. A health care clearinghouse is an organization that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.

will be required to transition to the 10th revision of the ICD codes (ICD-10).[4] Compared to the 9th revision of the ICD codes (ICD-9) currently in use, ICD-10 codes allow for greater specificity in describing patient diagnoses and in classifying inpatient procedures. CMS has a role in preparing covered entities for the transition to ICD-10 codes, and in engaging stakeholder organizations in preparing their members for the transition.

The transition to ICD-10 codes requires both CMS and covered entities to develop, test, and implement information technology systems that can process the new codes. In addition, these covered entities need to educate and train staff in using these new codes, and may need to modify internal business processes. This transition was initially to take effect on October 1, 2013, but this deadline was pushed back twice; the most recent change resulted in the current compliance deadline of October 1, 2015.[5] According to some stakeholders representing covered entities, the delays have been costly and burdensome to covered entities that were

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[4]According to the Statistics of U.S. Businesses, there were 283,272 firms in the United States in 2011 in the following industries: direct health and medical insurance carriers, third party administration of insurance and pension funds, offices of physicians, outpatient care centers, medical and diagnostic laboratories, home health care services, other ambulatory health care services, hospitals, and nursing and residential care facilities. This total does not include other firms affected by the transition to ICD-10 codes, such as durable medical equipment suppliers. See U.S. Bureau of the Census, Statistics of U.S. Businesses, "*Number of Firms, Number of Establishments, Employment, and Annual Payroll by Enterprise Employment Size for the United States, All Industries: 2011*," available at http://www.census.gov/econ/susb/.

[5]On January 16, 2009, HHS issued regulations that mandated the use of ICD-10 codes by October 10, 2013. On September 5, 2012, HHS finalized regulations delaying the effective date until October 1, 2014. The Secretary of HHS made this decision for the following three reasons: (1) the industry transition to the revised set of HIPAA electronic transaction standards, known as Version 5010, did not proceed as effectively as expected; (2) providers became concerned that other statutory initiatives, such as the Electronic Health Records Program and the Electronic Prescribing Program were stretching their resources; and (3) there was a lack of readiness for the ICD-10 transition, as indicated by industry surveys and polls. The Protecting Access to Medicare Act of 2014, enacted April 1, 2014, delayed the transition further by requiring HHS to transition to the use of ICD-10 codes no sooner than October 1, 2015. On August 4, 2014, HHS established October 1, 2015, as the new compliance date by issuing a final rule.

prepared for the earlier transition date.[6] Conversely, other covered entities that were concerned that they would not be ready for an earlier implementation date welcomed the delays.

You asked us to study the actions planned and taken by CMS to support the transition of covered entities to ICD-10 codes by October 1, 2015. In this report, we (1) evaluate the status of CMS's activities to support covered entities in the transition from ICD-9 to ICD-10 coding by that date; and (2) describe stakeholders' most significant concerns and recommendations regarding CMS's activities to prepare covered entities for the ICD-10 transition, and how CMS has addressed those concerns and recommendations.[7]

To describe CMS's role in supporting covered entities in the transition from ICD-9 codes to ICD-10 codes by October 1, 2015, we analyzed information and materials made publicly available through CMS's ICD-10 websites, and reviewed other documentation provided by CMS, such as planning documents outlining the agency's strategy for preparing covered entities for the transition. In addition, we interviewed CMS officials responsible for overseeing the agency's ICD-10 transition activities. To provide information on areas where covered entities perceive that CMS's activities related to the ICD-10 transition have been helpful, we analyzed information collected from a non-probability sample of 28 stakeholder organizations we contacted. To do so, we first identified a non-probability sample of 36 national stakeholder organizations to collect information that is representative of the views of the covered entities they represent, as

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[6]In its rule establishing an effective date of October 1, 2015, HHS estimated the cost of the one-year delay on some, but not all covered entities: between $547 million and $2.8 billion for commercial health plans and third party administrators; between $21 million and $32 million for Medicare; between $169 million and $182 million for Medicaid agencies; and between $409 million and $3.7 billion for hospitals and large physician practices.

[7]We are separately examining CMS's plans for modifying and testing the agency's claims processing systems in preparation for the ICD-10 transition, as well as CMS's testing activities.

well as the vendors that support those covered entities.[8] Our criteria for selecting these stakeholders were as follows: national organizations that participated in one of CMS's stakeholder collaboration meetings held in 2013; additional national organizations identified by CMS as a resource on the agency's ICD-10 website;[9] organizations that, according to the American Medical Association, represent medical professions that might be particularly impacted by the transition or have unique insights; the Healthcare Administrative Technology Association, a new organization identified by CMS as important because it represents practice management system vendors; and other organizations we identified to ensure that we had representation from each of the broad categories of non-federal affected covered entities identified by CMS in developing its regulations. For example, CMS identified outpatient care centers as covered entities impacted by the ICD-10 transition in conjunction with issuing a final rule in January 2009.[10] Because those covered entities were not already represented by one of the previously identified national organizations, we selected a national organization representing ambulatory surgical centers, which are a type of outpatient care center. This process identified a total of 36 stakeholders, which we contacted to request information. We analyzed the responses of 28 of these

[8]The vendors whose goods or services health care providers may utilize to help them code and process claims, such as electronic health record vendors and practice management system vendors, are not covered entities, but they must respond to HIPAA standards in order to support their HIPAA-covered customers. In our report, we did not collect information from stakeholders representative of property and casualty insurance plans, workers' compensation programs, and disability insurance programs, which are also affected by the transition to ICD-10 codes but are not HIPAA-covered entities.

[9]See the provider resources, Medicare fee-for-service resources, payer resources, and vendor resources pages at http://www.cms.gov/ICD10.

[10]Specifically, we compared the covered entities identified in the preamble to CMS's 2009 code set final rule to the list of stakeholders identified from the prior steps. See HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards To Adopt ICD–10–CM and ICD–10–PCS. 74 Fed. Reg. 3328 (Jan. 16, 2009). ICD-10, Clinical Modification (ICD-10-CM) refers to the subset of diagnosis codes captured in ICD-10, whereas ICD-10, Procedure Coding System (ICD-10-PCS) refers to ICD-10 procedure codes used in inpatient hospital settings.

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stakeholders, which we obtained either in an interview or in writing.[11] We did not include in our analysis the responses from 7 stakeholders that did not provide substantive responses to some of our questions,[12] and 1 organization declined to respond to our request for information. We collected information from stakeholders from August 2014 through October 2014.

To describe stakeholders' concerns and recommendations regarding CMS's activities to prepare covered entities for the ICD-10 transition, we analyzed information collected from the 28 stakeholders to identify the actions those stakeholders suggested CMS could undertake. To describe how CMS has addressed those concerns and recommendations identified by stakeholders, we interviewed CMS officials and reviewed agency documentation.

We conducted this performance audit from July 2014 to January 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that

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[11]We included responses from the following 28 stakeholders in our analysis: Ambulatory Surgery Center Association; American Academy of Family Physicians; American Academy of Orthopaedic Surgeons; American Academy of Professional Coders; American Ambulance Association; American Clinical Laboratory Association; American College of Cardiology; American College of Physicians; American Congress of Obstetricians and Gynecologists; American Health Information Management Association; American Hospital Association; American Medical Association; American Medical Billing Association; American Nurses Association; America's Health Insurance Plans; Blue Cross and Blue Shield Association; Cooperative Exchange; Federation of American Hospitals; Healthcare Administrative Technology Association; Healthcare Billing & Management Association; Healthcare Information and Management Systems Society; Medical Group Management Association; National Association of Community Health Centers; National Association of Rural Health Clinics; National Council for Prescription Drug Plans; National Rural Health Association; Professional Association of Health Care Office Management; and Workgroup for Electronic Data Interchange.

Throughout the report, we use the phrase "stakeholders we contacted" to refer to the 28 stakeholders from which we collected and analyzed information.

[12]We only included in our analysis stakeholders that provided substantive responses to both of the following questions: which CMS activities related to preparing covered entities for the ICD-10 transition have been helpful; and which CMS activities need improvement, and what additional activities are needed to help prepare covered entities for the ICD-10 transition?

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.
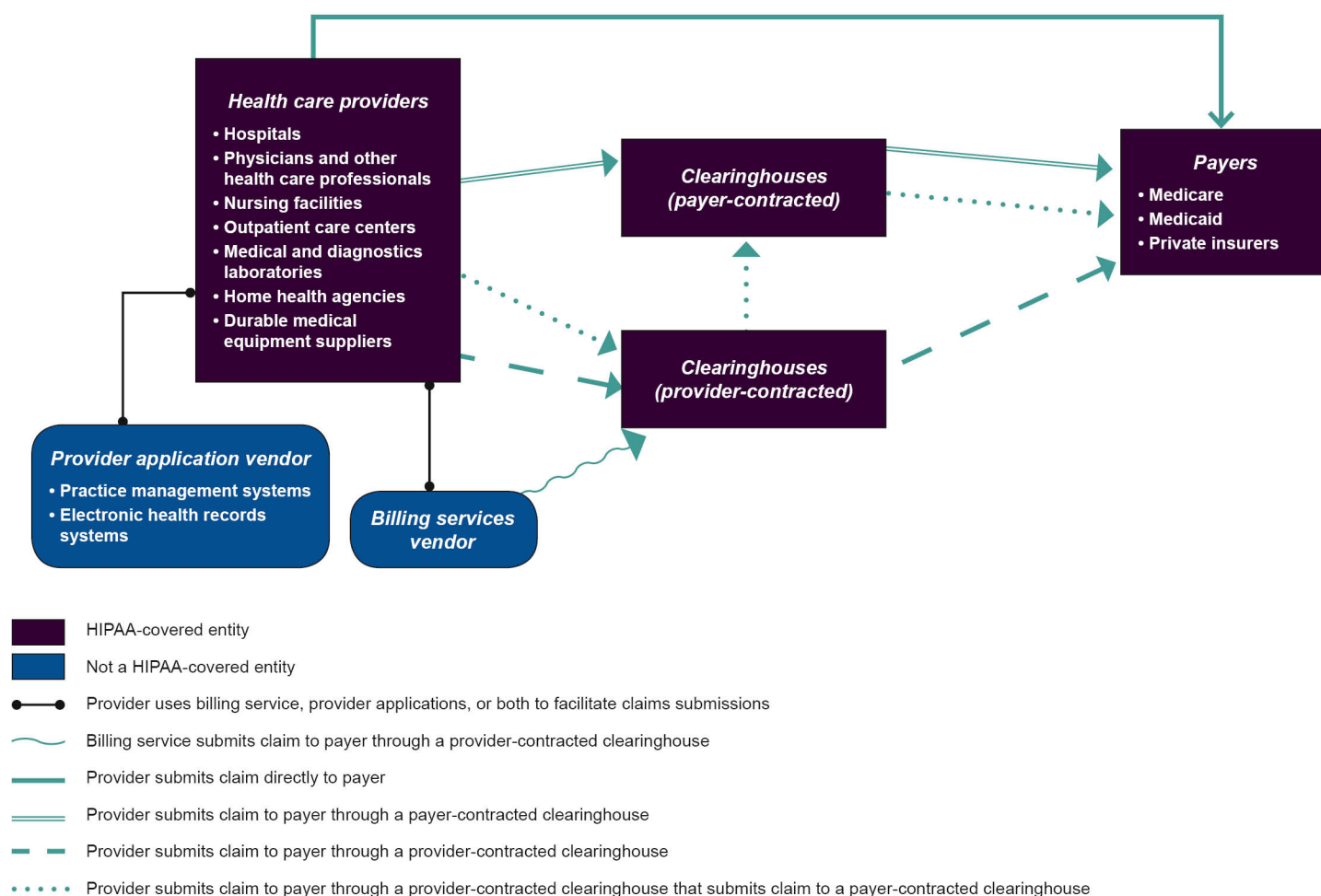
Background

The transition to ICD-10 codes, which has widespread implications for health care transactions and quality measurement in the United States, offers the potential for several improvements over the current ICD-9 code set. Medicare and Medicaid will incorporate the ICD-10 codes into multiple program functions that currently use ICD-9 codes, including payment systems and quality measurement programs.

ICD Code Overview

ICD-9 codes were initially adopted in the United States as the standard for documenting morbidity and mortality information for statistical purposes, but was expanded and adopted in 2000 through HIPAA as the standard code set for use in all electronic transactions by covered entities. Specifically, ICD-9 codes are used in all U.S. health care settings to code diagnoses and are also used in all U.S. inpatient hospital settings to code procedures. Beginning on October 1, 2015, all health care transactions that include ICD codes must use ICD-10 codes for dates of service that occur on or after that date. Transactions with dates of service that occur prior to the transition date of October 1, 2015, must continue to be coded with ICD-9 codes. The vendors whose goods or services health care providers may utilize to help them code and process claims, such as electronic health record vendors and practice management system vendors, are not covered entities, but they must respond to HIPAA standards in order to support their HIPAA-covered customers.[13] Figure 1 illustrates the flow of health care transactions that include ICD codes from the health care provider to payers, and identifies which types of organizations are and are not covered entities.

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[13]Practice management systems are technology applications that assist health care professionals in billing, electronic claims processing, recording patient demographics, and appointment scheduling.

Figure 1: Health Care Transaction Flow from Health Care Providers to Payers

Health care providers
- Hospitals
- Physicians and other health care professionals
- Nursing facilities
- Outpatient care centers
- Medical and diagnostics laboratories
- Home health agencies
- Durable medical equipment suppliers

Clearinghouses (payer-contracted)

Payers
- Medicare
- Medicaid
- Private insurers

Clearinghouses (provider-contracted)

Provider application vendor
- Practice management systems
- Electronic health records systems

Billing services vendor

■ HIPAA-covered entity

■ Not a HIPAA-covered entity

●—● Provider uses billing service, provider applications, or both to facilitate claims submissions

∿ Billing service submits claim to payer through a provider-contracted clearinghouse

── Provider submits claim directly to payer

══ Provider submits claim to payer through a payer-contracted clearinghouse

– – Provider submits claim to payer through a provider-contracted clearinghouse

• • • • Provider submits claim to payer through a provider-contracted clearinghouse that submits claim to a payer-contracted clearinghouse

Source: The Workgroup for Electronic Data Interchange and GAO analysis of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and CMS regulations. | GAO-15-255

Notes: The figure does not list all HIPAA-covered entities or vendors that may be affected by the transition to the 10th revision of the International Classification of Diseases (ICD-10) codes beginning on October 1, 2015. Although provider application and billing services vendors are not HIPAA-covered entities, to support their customers—that is, health care providers that are HIPAA-covered entities—these vendors' goods and services must use ICD-10 codes for dates of service that occur on or after October 1, 2015. A practice management system is a technology application that assists health care professionals in billing, electronic claims processing, recording patient demographics, and appointment scheduling. A clearinghouse is a HIPAA-covered entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.

The Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics is responsible for developing the ICD-10 diagnosis codes with input from medical specialty societies, and CMS is responsible for developing the ICD-10 procedure codes. Representatives from CMS

and the National Center for Health Statistics comprise the Coordination and Maintenance Committee, which is responsible for approving coding changes and making modifications, based upon input from the public. CDC and CMS, assisted by the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA)—collectively known as the Cooperating Parties—are responsible for supporting covered entities' transitions to ICD-10.[14] The Cooperating Parties' responsibilities include developing and maintaining guidelines for ICD-10 codes and developing ICD-10-related educational programs.

In addition to the Cooperating Parties, other organizations are helping to prepare covered entities for the ICD-10 transition. For example, officials with the Workgroup for Electronic Data Interchange (WEDI), a coalition of covered entities, vendors, and other members of the health care industry, hold regular meetings with industry members to discuss how to address ICD-10 transition issues. Additionally, WEDI and other stakeholders have made educational materials available on their websites.[15] For example, the Healthcare Information and Management Systems Society's ICD-10 Playbook contains tools, guidelines, and information to help covered entities prepare for the transition to ICD-10 codes. Stakeholders have also held sessions on ICD-10 transition-related issues during their member conferences.

There are several differences between ICD-9 and ICD-10 codes. For example, ICD-10 codes can include up to seven alphanumeric digits, while ICD-9 codes can only include up to five alphanumeric digits. The additional digits in ICD-10 codes allow for the inclusion of more codes. Specifically, there are approximately 15,000 ICD-9 diagnosis codes compared to approximately 70,000 ICD-10 diagnosis codes, and approximately 4,000 ICD-9 procedure codes compared to approximately 72,000 ICD-10 procedure codes. Despite the dramatic increase in the

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[14]AHA and AHIMA also have other responsibilities in supporting the ICD-10 transition. AHA houses the Central Office™, which serves as a clearinghouse for issues related to the use of ICD-9 and ICD-10 codes. Additional Central Office activities include recommending changes to ICD; developing educational materials; and publishing a quarterly newsletter that provides educational articles on ICD-9 and ICD-10 and responds to frequently asked questions. AHIMA provides ICD-10 training for coders and others, hosts ICD-10-related conferences and audio seminars, and produces ICD-10-related journal articles.

[15]WEDI was also identified in HIPAA as an advisor to HHS.

number of ICD-10 codes, according to CMS and others, most physician practices use a relatively small number of diagnosis codes that are generally related to a specific type of specialty.

The additional number of ICD-10 codes enables providers and payers to capture greater specificity and clinical information in medical claims. For example, ICD-10 codes enable providers to report on the body part and the side of the body subject to the evaluation or procedure. More specifically, while there was 1 ICD-9 code for angioplasty—a procedure to restore blood flow through an artery—there are 854 ICD-10 codes for angioplasty, with codes including additional detail on the body part, approach, and device used for the procedure. Another difference between ICD-9 and ICD-10 codes is the terminology and disease classifications, which have been updated so that they are consistent with new technology and current clinical practice. For example, under ICD-9, there was a single code to reflect tobacco use or dependence. Under ICD-10, there is a category for nicotine dependence with subcategories to identify the specific tobacco product and nicotine-induced disorder. The updated disease classifications for nicotine disorders reflect the increased knowledge of the effects of nicotine. Other differences between ICD-9 and ICD-10 codes include the addition of new concepts that did not exist in ICD-9 diagnosis codes, such as the expansion of postoperative codes to distinguish between intraoperative and post-procedural complications; and the designation of trimester for pregnancy codes.

Usage of ICD Codes

The ICD codes are used in a variety of ways by payers, including Medicare and Medicaid. For example, payers generally use ICD diagnosis codes to determine whether the care provided by physicians is medically necessary and, therefore, eligible for reimbursement.[16] Additionally, Medicare hospital inpatient payment rates are based on Medicare-Severity Diagnosis-Related Groups (MS-DRG), a system that classifies inpatient stays according to both patients' diagnoses and the procedures the patients receive, both of which are identified using ICD codes. The MS-DRG signifies the average costliness of inpatient stays

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[16]The amount of the reimbursement for physicians and other non-inpatient health care providers, however, is based on Current Procedural Terminology® (CPT). In the United States, CPT is the standard for coding professional services on claims submitted by physicians and other non-inpatient health care providers, and this will not change with the transition to ICD-10 codes.

assigned to one MS-DRG category relative to another MS-DRG category. All payers will need to update all systems and processes that utilize ICD codes by October 1, 2015, to ensure they are ICD-10 compliant.

In addition to claims processing, Medicare, Medicaid, and private payers conduct a variety of quality measurement activities that use quality measures, which will need to be updated to reflect the ICD-10 codes. For example, Medicare providers collect and report quality measures to CMS for the Hospital Inpatient Quality Reporting program, the Physician Quality Reporting System, the Physician Value-based Payment Modifier Program, and the Electronic Health Records program, and many private payers measure their performance using Healthcare Effectiveness Data and Information Set® (HEDIS) measures.[17]

CMS Developed Transition Educational Materials, Modified Medicare Systems, and Assisted Medicaid Agencies

In preparation for the transition from ICD-9 to ICD-10 codes, CMS developed various educational materials, conducted outreach, and monitored the readiness of covered entities and the vendors that support them for the transition. In addition, the agency reported modifying its Medicare systems and policies. CMS also provided technical assistance to Medicaid agencies and monitored their readiness for the ICD-10 transition.

CMS Developed Educational Materials, Conducted Outreach, and Assessed Covered Entity and Vendor Readiness

CMS developed a variety of educational materials for covered entities, available on the agency's ICD-10 website,[18] to help them prepare for the transition to ICD-10 codes. Each of the 28 stakeholders we contacted reported that the educational materials CMS made available have been helpful to preparing for the ICD-10 transition. Some of the materials CMS developed are specific to small and medium physician practices, large practices, or small hospitals. CMS officials told us that the agency developed these materials in response to feedback the agency received

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[17]HEDIS measures were developed by the National Committee for Quality Assurance to measure and compare the performance of health plans in providing selected services.

[18]CMS's ICD-10 website is available at http://www.cms.gov/ICD10 and contains information targeted to different audiences—that is, providers, payers, and vendors.

from stakeholders that indicated that these specific groups wanted materials targeted to them. The educational materials include

- documents that provide information about ICD-10 codes, including how they differ from ICD-9 codes, and explain why the transition is occurring;

- checklists and timelines that identify the steps necessary to prepare for the transition, including the associated timeframes;

- tip sheets on how providers should communicate with the vendors that supply their practices with products that utilize ICD coding—such as software vendors and billing services—and vice versa;

- videos and webinars; and

- links to stakeholder websites that also feature ICD-10 guidance and training materials.[19]

In addition, CMS officials told us that the agency partnered with organizations to enable providers to obtain continuing medical education credit for eight training modules as a way to incentivize providers to prepare for the transition.

To help small practices prepare for the ICD-10 transition, and in response to focus group feedback, CMS launched a new website in March 2014 called "Road to 10."[20] According to CMS documentation dated March 2013, industry feedback received by the agency indicated that small physician practices lag behind other providers in preparing for the transition. Seventeen of the 28 stakeholders we contacted noted that this website was helpful in preparing covered entities for the transition. The Road to 10 website, which can be accessed through CMS's main ICD-10 website, provides additional training materials not available through CMS's main ICD-10 website, including training videos describing the clinical documentation needs for the following specialties: cardiology, family practice and internal medicine, obstetrics and gynecology, orthopedics, and pediatrics. The website also provides a customizable action plan based on several criteria: specialty; practice size; types of

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[19]Some stakeholders we contacted told us that they distribute CMS's educational materials to their members.

[20]The website is http://www.roadto10.org/.

vendors supporting the practice, such as an electronic health record system vendor; payers to whom the clinician submits claims; and the level of readiness for the ICD-10 transition.

Some of CMS's educational materials are intended to help covered entities determine which ICD-10 codes they may need to use. Specifically, CMS and the other members of the Cooperating Parties developed a tool called the General Equivalence Mappings to assist covered entities in converting ICD-9 codes to ICD-10 codes. Covered entities can use the General Equivalence Mappings tool to identify ICD-10 codes that might be most relevant to them—a practice that CMS advocates in its checklists and action plans.[21] Six of the 28 stakeholders we contacted described this tool as being helpful to their preparatory activities. CMS's Road to 10 website also identifies common ICD-10 diagnosis codes associated with the following six physician specialties: cardiology, family practice, internal medicine, obstetrics and gynecology, orthopedics, and pediatrics.

CMS also conducted a number of outreach activities in order to inform covered entities and others about the educational materials that are available, educate and engage covered entities, obtain real-time feedback on areas that may merit additional activities from CMS, and promote collaboration among stakeholders. Twenty-two of the 28 stakeholders we contacted reported that CMS's outreach activities have been helpful in preparing covered entities for the transition to ICD-10 codes. Examples of the types of outreach CMS has conducted include the following.

- Email lists, social media, and advertisements. CMS communicated information related to the ICD-10 transition through several email lists, the primary one being the ICD-10 email list, which CMS officials said was distributed to 186,000 email addresses as of November 25, 2014. The emails communicated information related to the ICD-10 transition and generally directed recipients to CMS's ICD-10 website, which agency officials told us receives approximately 184,000 page views per month. Our review of the emails sent from August 2013 to August

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[21]The General Equivalence Mappings translate ICD-9 codes to ICD-10 codes and vice versa; however, there is not a one-to-one match between ICD-9 and ICD-10 codes for several reasons, including that some new concepts are present in ICD-10 codes that were not captured in ICD-9 codes, and because many ICD-10 codes are more specific than ICD-9 codes—that is, one ICD-9 code may be represented by multiple ICD-10 codes.

2014 indicated that CMS communicated a variety of information, including available trainings and separate specialty-specific trainings; best practices; and resources available to help covered entities prepare for the transition. Other CMS email lists also communicated information related to the ICD-10 transition, including eHealth and Medicare Learning Network® (MLN) Connects™.[22] CMS officials told us that other groups redistribute CMS's emails to their members, which helped the agency reach additional covered entities. For example, officials said that approximately 140 national associations distribute the information to their members, which represent over 3 million individuals, and that the Medicare Administrative Contractors (MAC) forward these messages to their email lists, which include about 600,000 addresses.[23] CMS's regional offices also distribute materials through their local email lists, according to CMS officials. In addition, CMS's Twitter account provided information about the ICD-10 transition, such as the date by which covered entities must use ICD-10 codes, and provided links to educational materials and information about upcoming presentations. CMS officials told us that the agency has placed and plans to place additional advertisements about the transition in both print and online resources, such as journals and associations' publications.

- National broadcasts. CMS hosted teleconferences that provided an overview of key transition issues, and an opportunity for participants to ask questions.[24] In addition, according to the publisher, in 2013, CMS participated in four broadcasts of Talk 10 Tuesdays, a weekly 30-minute Internet radio broadcast directed to healthcare providers transitioning to ICD-10, which has about 6,800 registered listeners.

- Stakeholder collaboration. CMS has collaborated with stakeholders in various ways. For example, in 2013, CMS held two meetings with stakeholders that represented covered entities and vendors. In those meetings, stakeholders noted several concerns related to the ICD-10 transition and made recommendations to CMS. In addition, CMS officials reported holding 40 one-on-one meetings with 31 individual stakeholders between January 2013 and March 2014. Topics of

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[22]CMS officials noted that the MLN Connects *Provider eNews* email list was distributed to about 202,000 email addresses as of November 25, 2014.

[23]MACs are companies contracted by CMS to process Medicare claims.

[24]After they occur, CMS makes recordings of these teleconferences available on its website.

stakeholder collaboration meetings included the effectiveness of existing educational materials and how to communicate the benefits of ICD-10 coding to the public. CMS officials also presented information about the ICD-10 transition at conferences held by stakeholders. In addition, CMS hosted two live events (in April 2011 and September 2014) where members of the American Academy of Professional Coders answered questions about the ICD-10 codes. Fifteen of the 28 stakeholders we contacted mentioned that CMS's outreach to or collaboration with stakeholders has been helpful to preparing covered entities for the transition. Officials with one of these stakeholders noted that CMS's participation in stakeholder meetings demonstrates that CMS is listening to the health care industry's concerns.

CMS has begun to conduct additional outreach to small primary care physician practices. First, CMS started to conduct in-person training for small physician practices in a number of states. According to CMS officials, between February and December 2014, CMS held 90 1-to-2 hour trainings in 29 states and the District of Columbia; in each one, between 1 and 12 sessions were held.[25] In January 2015, officials said the agency will begin scheduling trainings that will occur in 2015. CMS officials said that the content for these trainings was based on feedback from physician focus groups about what physicians are most interested in learning about during the sessions. In addition, CMS piloted a direct mail project to small primary care practices in four states—Arizona, Maryland, Ohio, and Texas—and CMS officials told us they planned to complete an assessment of the pilot in early December 2014. In responding to a draft of this report, CMS officials stated that the agency plans to expand the pilot to rural communities. CMS officials stated that the agency is working with stakeholders to identify specific practice locations to send direct mail, an activity they plan to begin in March 2015 and conclude in May 2015; however, CMS officials did not identify the number of practices the agency plans to target for this effort.

In addition to developing educational materials and conducting outreach, CMS conducted activities to assess the readiness of covered entities and vendors. For example, to prepare for the original implementation date of

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[25]CMS held these trainings in the following states: Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Montana, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, West Virginia, and Wyoming. CMS also held trainings in the District of Columbia.

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October 1, 2013, CMS's contractors conducted an assessment of the health care industry's ICD-10 transition planning in 2009.[26] Additionally, in 2011, CMS's contractors interviewed 27 organizations representing vendors, payers, and small physician practices, and surveyed almost 600 organizations regarding their awareness of and preparation for the transition to ICD-10 codes.[27] These activities revealed a number of things, including that covered entities wanted additional guidance on how to prepare for the transition, such as templates describing testing steps; that providers were concerned about the time and costs associated with the transition; and that 82 percent of providers, 88 percent of payers, and 75 percent of vendors contacted believed they would be ready to use ICD-10 codes by the original October 1, 2013, transition date. More recently, CMS has relied on its stakeholder collaboration meetings, focus group testing, and review of surveys conducted by the health care industry to gauge covered entities' readiness for the transition, according to agency officials. During the course of our work, we learned that CMS planned to conduct a survey to assess current covered entity and vendor readiness. However, in commenting on a draft of this report, HHS told us that CMS had decided not to go forward with those plans, as CMS determined that the agency's limited resources would be better spent continuing its outreach activities due to the rapidly approaching transition deadline.

CMS Reported Having Begun Modifying Medicare Systems and Policies for the Transition

CMS reported that the agency has begun modifying Medicare's systems and policies in preparation for the ICD-10 transition. Examples of these activities include the following:

- Coverage policies. CMS and its MACs have updated National Coverage Determination and Local Coverage Determination polices,

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[26]Gartner, *Industry Planning for Implementation of HIPAA Modifications: Versions 5010, D.0, 3.0 and the ICD-10 code sets,* February 2010.

[27]CMS, *ICD-10 and Version 5010: Industry Readiness Assessments,* August 2011; and Ketchum Inc., *Version 5010 and ICD-10 Readiness Assessment,* December 2011.

The results of all three assessments, including the Gartner study, which were conducted in support of the original transition date of October 1, 2013, are available at http://www.cms.gov/Medicare/Coding/ICD10/CMSImplementationPlanning.html.

which identify the items and services that are covered by Medicare to reflect the conversion to ICD-10 codes.[28]

- Medicare fee-for-service (FFS) claims processing systems. CMS documentation states that the agency completed all ICD-10-related changes to its Medicare FFS claims processing systems as of October 1, 2014, and that the claims processing systems have been updated in response to the results of internal testing, but it is not yet known whether updates may be needed based upon the results of external testing.

  - Internal testing. CMS has reported that its Medicare claims processing systems reflect different types of internal testing activities.[29] For example, each MAC conducted testing to ensure that claims using ICD-10 coding complied with the Local Coverage Determination policies, and that the claims processing systems appropriately accepted or rejected and processed claims.

  - External testing. CMS had not completed testing with external parties, and agency officials acknowledged that the agency would make additional changes to its systems if future testing identified any issues. Specifically, CMS conducted "acknowledgment testing"—that is, testing to determine whether claims submitted by providers and suppliers that contain ICD-10 codes were accepted or rejected—over two separate weeks in 2014 (one week in March and one in November). CMS plans to hold two additional weeks of acknowledgement testing in 2015 (one week in March and one in June). In addition, CMS has plans to conduct such testing with any covered entity that submits test claims on an ongoing basis until October 1, 2015. During CMS's first acknowledgement

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[28]National Coverage Determinations are policies developed by CMS that identify the items and services that are covered by Medicare for all Medicare beneficiaries meeting the criteria for coverage, regardless of the location of the service. In contrast, Local Coverage Determinations are specific to the location of the service and are developed by MACs when there is no National Coverage Determination or when there is a need to more specifically define a National Coverage Determination.

[29]Unrelated to the ICD-10 transition, CMS releases regular quarterly updates to its Medicare FFS claims processing systems to incorporate changes to Medicare FFS policy, changes in law, or to correct for errors. CMS officials told us that internal testing for the regular quarterly updates begins 3 months prior to the release of the quarterly update. CMS officials stated that they plan to release three additional quarterly releases on or before the October 1, 2015, deadline (April 1, 2015; July 1, 2015; and October 1, 2015). These releases will also undergo internal testing activities.

testing week in March 2014, the agency reported that 2,600 covered entities submitted more than 127,000 claims—89 percent of which were accepted, with some regional variation in acceptance rates.[30] During CMS's second acknowledgement testing week in November 2014, the agency reported that 500 covered entities submitted about 13,700 claims—76 percent of which were accepted.[31] CMS documentation indicates that testing during the March and November 2014 acknowledgment testing weeks did not identify any issues with the agency's Medicare FFS claims processing systems. Additionally, CMS plans to conduct "end-to-end testing"—that is, testing to determine how claims submitted by providers and suppliers that contain ICD-10 codes would be adjudicated, and that accurate payments for these claims will be calculated—during three weeks in 2015 (in January, April, and July). CMS is planning to conduct end-to-end testing with a total of 2,550 covered entities, or 850 covered entities in each week-long testing period.[32]

We did not independently assess the extent to which CMS's Medicare FFS claims processing systems have been updated or tested in preparation for the ICD-10 transition because we have separate ongoing work evaluating these activities.

- Hospital reimbursement. According to CMS documentation, the agency has converted MS-DRGs, which determine reimbursement rates to hospitals for inpatient hospital stays by Medicare beneficiaries, to reflect ICD-10 codes. CMS planned to continue making adjustments to the MS-DRGs, as appropriate, based upon input from the Coordination and Maintenance Committee and from public comments.[33] The version of the MS-DRG that will be

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[30]According to CMS officials, the normal Medicare FFS claims processing acceptance rates average between 95 and 98 percent.

[31]According to CMS documentation, the majority of rejections on claims submitted for health care professionals during the November 2014 testing period were related to an invalid National Provider Identifier, a unique identifier for each health care professional.

[32]CMS has indicated that each of the 16 MACs and the Railroad Retirement Board payment contractor will select 50 volunteer covered entities to provide a representative sample of submitters, and that each submitter will be permitted to submit 50 test claims.

[33]CMS officials stated that based on public comment, CMS could make adjustments to the MS-DRG to assign inpatient hospital stays to different MS-DRG categories, to add MS-DRG categories, or to reflect changes to ICD-10 codes.

implemented on October 1, 2015, is to be made available to the public in the summer of 2015.[34] CMS documentation suggests that until the new version of the MS-DRG is provided, hospitals may use the documentation and software CMS has already made available to analyze the effect the conversion to ICD-10 codes will have on hospital payments.

CMS has employed different strategies to communicate the changes it has made to its systems and policies. The agency distributes educational materials through the MLN. For example, CMS has issued articles that instruct providers and suppliers (e.g., inpatient hospitals and home health agencies) on how to code claims that span a period of time that crosses the ICD-10 compliance date of October 1, 2015. In addition, the MACs help educate and provide information to Medicare providers and suppliers. For example, the MACs are to distribute information to providers and suppliers about the acknowledgement testing weeks.

CMS Provided Technical Assistance and Monitors the Readiness of Medicaid Agencies

CMS provided technical assistance to Medicaid agencies in states and the District of Columbia to help them prepare for the ICD-10 transition.[35] For example, CMS developed educational and guidance tools, such as an implementation handbook, which identified five implementation phases: (1) awareness, (2) assessment, (3) remediation, (4) testing, and (5) transition. In addition, according to the CMS official leading these

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[34]Version 32 of the MS-DRG has been updated to ICD-10 codes and is currently available on CMS's website; however, the agency has indicated that version 33 will be the final version implemented on October 1, 2015, and will reflect changes resulting from the agency's annual rulemaking process for inpatient prospective payment systems for acute care hospitals for fiscal year 2016. In general, this means that the proposed rule would be published in the spring of 2015 and the final rule would be published in the summer of 2015.

[35]States (including the District of Columbia) are required to have in operation a mechanized claims-processing and information-retrieval system based on certain federal requirements. 42 U.S.C. §1396b(r). These systems, known as Medicaid Management Information Systems, are tailored to the needs of each state's Medicaid program; thus, there is variation among the systems.

CMS is required to reimburse states for a percentage of the costs associated with modifying and operating their Medicaid Management Information Systems. 42 U.S.C. §1396b(a)(3). Subject to CMS approval, states are eligible for 90 percent of the costs associated with changes to their systems as a result of the ICD-10 transition; 90 percent of the costs associated with internal and external testing activities; and 75 percent of the costs associated with personnel training.

technical assistance activities, CMS conducted about 60 onsite training sessions with Medicaid agencies. By January 2015, CMS officials said the agency will have conducted site visits to 12 Medicaid agencies that need additional assistance to prepare for the transition, and will conduct additional trainings as needed. CMS also provides technical assistance to Medicaid agencies in other ways. For example, a CMS official noted that the agency advised Medicaid agencies on their testing plans and worked with them on their development of risk mitigation plans related to provider readiness. In addition, CMS officials noted that the agency hosts bi-weekly meetings with Medicaid agencies, which include selected external stakeholders, such as other payers and health care providers, during which Medicaid agencies share information, lessons learned, and best practices related to the ICD-10 transition.

CMS also monitors the readiness of Medicaid agencies for the ICD-10 transition. For example, CMS officials noted that the agency assesses the readiness of Medicaid agencies quarterly and holds conference calls with each one. According to CMS officials, as of October 2014, all states and the District of Columbia reported that they would be able to perform all of the activities that CMS has identified as critical to preparing for the ICD-10 transition by the deadline.[36] These critical success factors are the ability to accept electronic claims with ICD-10 codes; adjudicate claims; pay providers (institutional, professional, managed care); complete coordination of benefits with other insurers; and create and send Medicaid system reports to CMS. CMS officials stated that all Medicaid agencies must test each of the critical success factors and report back to CMS no later than June 30, 2015.[37] However, as of November 26, 2014, not all Medicaid agencies had started to test their systems' abilities to accept and adjudicate claims containing ICD-10 codes. Specifically, CMS officials told us that 2 states had completed internal and external testing,

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[36]CMS officials said that this information is based on responses to information obtained from Medicaid agencies in September and October 2014, as well as CMS officials' review of Medicaid agency documentation.

[37]To assist Medicaid agencies in conducting external end-to-end testing, CMS officials stated that the agency has provided Medicaid agencies with a voluntary tool that will allow agencies to test their systems' capabilities to accept claims, adjudicate claims, and pay providers. CMS officials stated that the web-based testing tool provides Medicaid agencies 2,750 testing scenarios and the capability to develop custom scenarios in collaboration with providers. Officials also noted that the tool helps Medicaid agencies to prioritize providers to test using criteria such as claims volume, and to analyze the test results.

9 states and the District of Columbia had started internal testing activities, and 16 states had started external testing activities.[38] The remaining 23 states, according to the CMS officials, were in the process of updating their policies and systems, which needs to occur before testing begins. Therefore, Medicaid agencies may need to make system changes if testing identifies issues.

Stakeholders Cited Testing Activities, Education, Outreach, and Provider Burden among Concerns; CMS Has Taken Steps to Address Concerns and Prepare for Transition

Stakeholders we contacted identified several areas of concern about the ICD-10 transition, including that CMS needed to expand the number of ICD-10 testing activities, with some of those stakeholders commenting that CMS's ICD-10 testing has not been sufficiently comprehensive. Stakeholders we contacted also noted areas of concern and made recommendations regarding CMS's ICD-10 education and outreach efforts, and requested that the agency mitigate any additional provider burdens leading up to and following the ICD-10 transition.

Testing. Twenty of the 28 stakeholders we contacted identified concerns or made recommendations related to CMS's ICD-10 testing activities. Their comments focused on CMS's lack of comprehensive ICD-10 testing, as well as the need to communicate the future test results to covered entities.

- Lack of comprehensive testing. Seventeen stakeholders raised concerns that CMS's ICD-10 testing was not comprehensive. Specifically, some of these stakeholders were concerned that CMS has not yet conducted Medicare FFS end-to-end testing. Additionally, some of these stakeholders were concerned that CMS would not include enough covered entities in its testing. For example, one stakeholder expressed concern that not all provider types, such as small providers, would be represented in the planned testing. Another stakeholder was concerned that the number of testing participants may not be large enough to get a true sense of industry readiness or the ability of CMS to properly process the full range of ICD-10 codes.

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[38]According to CMS officials, Indiana and Michigan have completed testing; Arizona, the District of Columbia, Idaho, New York, Ohio, Rhode Island, South Carolina, Texas, Utah, and West Virginia have started internal testing; and Alabama, Florida, Georgia, Iowa, Kansas, Kentucky, Massachusetts, Missouri, New Jersey, New Mexico, Nevada, Oklahoma, Tennessee, Vermont, Virginia, and Washington have started external testing.

As previously noted, CMS officials said that the agency has scheduled Medicare FFS end-to-end testing with a total of 2,550 covered entities during three separate weeks in 2015, and identified staffing and financial constraints as the reason for limiting the number of covered entities participating in the scheduled testing. However, agency officials indicated that the number of covered entities they plan to test with will exceed the number requested by some industry groups.[39] In addition, CMS officials said they are committed to ensuring that the testing participants are representative of the health care industry.

- Communicate test results. Seven stakeholders we contacted recommended CMS better communicate the agency's readiness for the ICD-10 transition, by, for example, improving communication of test results. Two of these stakeholders indicated that doing a better job communicating test results would not only increase confidence that CMS will be prepared to process claims, but also would help providers identify modifications needed in their own coding or billing practices.

  CMS officials noted that the agency intends to publicly release the results of Medicare FFS end-to-end testing once the agency has completed its analysis of each of the three scheduled testing periods. Specifically, CMS's communications plan indicates that the agency intends to report on the results of each testing period within a month of when the testing is completed. CMS officials told us that the report will provide details about the types and numbers of testing participants, technical challenges that arise during testing, and CMS's plans for fixing them.

Education. Twenty of the 28 stakeholders we contacted identified concerns or recommendations related to CMS's covered entity education efforts. Specifically, these stakeholders' comments focused on whether covered entities were aware of CMS's educational materials to help them prepare for the ICD-10 transition. These stakeholders suggested CMS emphasize benefits from transitioning to ICD-10, as well as best practices and success stories, expand in-person training, and develop more specialty-specific materials.

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[39]Independently evaluating CMS's testing plans is beyond the scope of this report. We are separately examining CMS's plans for modifying and testing the agency's claims processing systems in preparation for the ICD-10 transition, as well as its testing activities.

- <u>Covered entity awareness of educational materials</u>. Eleven stakeholders we contacted expressed concerns about the extent to which the covered entities they represent were aware of and using the educational materials developed by CMS. In particular, while all 28 stakeholders we contacted indicated that CMS's educational materials have been helpful to covered entities, some of them were concerned that the materials may not be reaching the covered entities most in need of them, such as solo or small physician practices, rural and critical access hospitals, nursing homes, and home health agencies.

  CMS officials indicated that all of the agency's outreach efforts—as described earlier in this report—have been intended to work in concert to promote awareness of the ICD-10 transition and direct covered entities, especially hard-to-reach entities, to helpful educational materials. CMS officials stated that the agency has partnered with a number of organizations to reach covered entities, including those covered entities that some stakeholders indicated are most in need of the materials. Specifically, CMS partnered with WEDI to create the "ICD-10 Implementation Success Initiative," a partnership between payers, providers, coding organizations, and other organizations to promote awareness of the ICD-10 transition by directing users to available CMS and industry educational resources. In addition, CMS officials indicated that the agency tracks the use of its educational materials by, for example, monitoring the number of documents downloaded or videos viewed, and uses the tracking information to customize and develop new information as needed. However, the agency's monitoring activities do not provide specific information on whether the providers most in need of these materials—which stakeholders identified as solo or small physician practices, rural and critical access hospitals, nursing homes, and home health agencies— are accessing and using them.

- <u>Place greater emphasis on sharing ICD-10 benefits, best practices, and success stories</u>. Seven stakeholders we contacted suggested that CMS put greater emphasis on sharing ICD-10 benefits, best practices, and success stories in order to increase support among providers for the transition.[40] Specifically, one stakeholder said that it would be helpful if CMS could identify "physician champions" who

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[40]According to CMS's "Road to 10" website, the benefits of ICD-10 include enhanced clinical documentation enabling physicians to better capture patient visit details, which may lead to better care coordination and health outcomes.

could discuss the benefits of transitioning to ICD-10, walk other physicians through the steps needed to prepare for the transition, and reassure them that they will not suffer financially in the process of preparing for the transition. Similarly, another stakeholder suggested that success stories could illustrate that the effort to comply with the ICD-10 transition may not be as difficult as anticipated. A third stakeholder mentioned that CMS could do more to explain how the transition to ICD-10 can create value in delivering patient care.

CMS officials highlighted agency materials that describe benefits, best practices, and success stories that are currently available on the Road to 10 website, and also described materials they are developing. For example, CMS officials identified website materials that describe clinical, operational, professional, and financial benefits of using ICD-10 codes, which are topics that physicians identified as resonating with them; and video testimonials from physician champions. CMS officials also noted that the agency is developing additional positive testimonials and best practice resources from providers and payers, as well as ICD-10 "use cases" that will provide practical examples of how ICD-10 codes will be used in a clinical setting. Officials noted that the development of these materials is part of an effort to share positive physician experiences as a way to re-engage physicians and other covered entities following the transition delay to October 1, 2015. CMS officials indicated that this information will be posted to the CMS website in December 2014, but did not provide additional details on the specific materials they plan to develop during the period of our review.

- Expand in-person training and provide more advance notice of those events. Six stakeholders we contacted recommended that CMS expand its in-person training for physician practices to additional states. Initially, CMS officials indicated that they planned to hold these in-person training events in 18 states.[41] One stakeholder remarked that every state has small or rural practices that are struggling to make the ICD-10 transition and could benefit from CMS's training

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[41]CMS officials said that they selected the initial 18 states based upon the following criteria: large Medicaid population and high concentration of small physician practices; federal recognition as being rural; and possible high risk for ICD-10 non-compliance. The initial 18 state selected were: California, Florida, Georgia, Illinois, Indiana, Michigan, Montana, New York, North Carolina, Ohio, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, Washington, West Virginia, and Wyoming.

activities. Another stakeholder indicated that CMS had initially only provided a few days' advance notice for scheduled training, and requested that CMS provide more advance notice.

CMS officials said the agency is expanding the in-person trainings to additional states, beyond the 18 states noted above, where resources allow. Specifically, as of January 2015, officials said that they had held trainings in 11 additional states.[42] CMS officials also indicated that the agency is collaborating with nationally and locally recognized organizations to expand training to additional states. Officials said that where resources are not available for in-person training, CMS is reviewing options to offer more video training through the ICD-10 website. In response to concerns about the notice provided for these events, CMS officials said that the Road to 10 website identifies scheduled in-person training events by location, and that the agency is working closely with the CMS regional offices, medical specialty associations, and other state and local partners to raise awareness of these events.

- Develop additional specialty-specific materials. Four stakeholders we contacted requested that CMS continue developing additional physician specialty-specific educational materials. For example, one stakeholder suggested that CMS develop more materials that focus on specific, practical examples of how the ICD-10 codes would be used in a clinical setting.

  CMS officials noted that the agency has made various specialty-specific materials available, and stated that the agency plans to add more specialty-specific educational materials to its Road to 10 website, and, as requested, will partner with stakeholders to develop materials targeted to their providers. In commenting on a draft of this report, CMS officials noted that the agency plans to develop materials for anesthesia, bariatric, general surgery, pulmonary, and renal specialties; however, they did not indicate when those materials will be made available on the website.

Outreach. Nineteen of 28 stakeholders we contacted recommended that CMS take additional actions that could improve its outreach efforts.

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[42]The additional states are Alabama, Arkansas, Colorado, Connecticut, Kentucky, Louisiana, Maryland, Mississippi, New Jersey, Oregon, and South Carolina. CMS officials told us that the agency also held trainings in the District of Columbia at the request of local associations.

Specifically, stakeholders recommended that the agency communicate plans to ensure that Medicare FFS providers would be reimbursed in a timely manner; provide information on the effect of the ICD-10 transition on CMS's quality measurement activities; contact providers through non-electronic methods, such as print media and mail; promote a greater sense of immediacy in preparing for the transition; provide information on alternative methods for Medicare claims submission; and make public CMS's Medicare FFS contingency plans.

- Communicate plans to ensure Medicare FFS payment. Seven stakeholders we contacted recommended that CMS take action to ensure that providers would be reimbursed in a timely manner if CMS's Medicare FFS claims processing systems are unable to accept and correctly process claims. These recommendations included the following: (1) expand the use of the agency's Medicare Part B advance payment policy to account for instances where MACs are unable to receive and, therefore, pay providers' claims;[43] (2) reimburse Medicare providers' claims even if there are problems with the ICD diagnosis codes submitted; and (3) allow Medicare providers to submit either ICD-9 or ICD-10 codes—referred to as dual coding—for a period of time following the October 1, 2015, transition deadline.

  CMS officials stated that the agency understands the importance of paying claims on time during the ICD-10 transition, and is committed to working closely with providers to ensure a smooth transition and responded to each of the recommendations:

  - CMS officials indicated that the agency's current authority permits CMS to determine circumstances that warrant the issuance of advance payments to affected physicians and suppliers providing Medicare Part B services, and that this authority could be used should CMS systems be unable to process valid Part B claims that contain ICD-10 codes beginning October 1, 2015. Under these circumstances, no action would need to be taken by the physician

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[43]Medicare Part B covers physician services, outpatient services, and some home health and preventive services.

CMS may provide an advance payment to Medicare Part B suppliers if a MAC is unable to process suppliers' claims within established time limits. This advance payment is conditional and subject to adjustment, recoupment, or both, based on an eventual determination of the actual amount due on the claim. 42 C.F.R. § 421.214.

or supplier, nor would the agency need to publish additional criteria or modify the existing advance payment policy, according to CMS officials.

- CMS officials stated that the submission of valid ICD-10 codes is a requirement for payment; however, when the presence of a specific diagnosis code is not required for payment then the claim would be paid even if a more appropriate ICD-10 code should have been used on the claim. For example, CMS officials told us that, because there are many reasons why an individual would need to go in for an office visit, office visits do not require the claim to include specific ICD-10 codes; therefore, as long as a claim for an office visit includes a valid ICD-10 code, it would be paid. Additionally, CMS officials indicated that, absent indications of potential fraud or intent to purposefully bill incorrectly, CMS will not instruct its contractors to audit claims specifically to verify that the most appropriate ICD-10 code was used. However, audits will continue to occur and could identify ICD-10 codes included erroneously on claims which could lead to claims denials, according to CMS officials.

- CMS officials said that dual processing of ICD-9 and ICD-10 codes on Medicare claims is not possible given that HIPAA does not allow for the use of two different code sets at the same time.

- Communicate how the ICD-10 transition affects CMS programs that use clinical quality measures. Six stakeholders we contacted expressed a need for more information on how the ICD-10 transition will affect CMS programs that make use of clinical quality measures. One stakeholder suggested that there is a lack of understanding about how the ICD-10 transition will affect quality measurement reporting.

  CMS officials indicated that the agency has already made some information available about how the ICD-10 transition will affect CMS's quality measurement activities, and has plans to make additional information available by January 2015. For example,

  - CMS officials noted that the quality measures for the Physician Quality Reporting System have been updated with ICD-10 codes, and that the agency communicated the effect of the transition through the 2014 Physician Quality Reporting System

implementation guide.[44] Agency officials reported that for 2015, quality measures will utilize ICD-9 codes for January through September 2015 and ICD-10 codes for October through December 2015. In December 2014, CMS made available documentation, which details when and which ICD-10 codes should be used in quality measure reporting for 2015.[45] Because the Physician Value-based Payment Modifier Program relies partially on the Physician Quality Reporting System measures, payment adjustments in that program for 2017 will also reflect ICD-9 codes for three quarters and ICD-10 codes for one quarter of 2015.[46]

• A version of the quality measures used in the Home Health Quality Reporting Program has been updated for ICD-10 codes and that version will be used beginning on October 1, 2015. CMS has communicated this approach through various means, including a section of the agency's Home Health Quality Initiative website.[47]

• For the hospital inpatient, hospital outpatient, and ambulatory surgical center quality reporting programs, CMS officials noted that the agency plans to issue updated specifications in April 2015 for discharges or encounters that occur on or after the ICD-10

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[44]Specifically, the glossary of that document notes the population to which the measure applies will be identified using ICD-9 codes for January through September 2014 and ICD-10 codes for October through December 2014. This document does not reflect the new ICD-10 compliance deadline. See CMS, *2014 Physician Quality Reporting System (PQRS): Implementation Guide*, version 8.5 (October 17, 2014), available at http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

[45]See CMS, *2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures,* version 9.1, December 23, 2014; and *CMS, 2015 Physician Quality Reporting System (PQRS) Measures Groups Specifications Manual,* version 8.1, December 22, 2014. Both documents are available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

[46]CMS officials noted that the agency plans to align the additional quality and cost measures utilized in the Physician Value-based Payment Modifier Program with other CMS programs, but did not specify how those other programs will address the transition to ICD-10 coding during the calendar year.

[47]See http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-C1.html.

transition deadline. In commenting on a draft of this report, CMS officials stated that CMS had made available a crosswalk of ICD-9 and ICD-10 codes for quality measures in the hospital inpatient and hospital outpatient quality reporting programs.

- Engage through non-electronic methods. Five stakeholders we contacted recommended that CMS do more to engage with covered entities through non-electronic methods. For example, one stakeholder indicated that not all of its members rely on electronic communications, instead relying on more traditional forms of receiving information—such as print media and mail—and suggested that CMS expand the methods it uses to engage with covered entities. Other stakeholders recommended that CMS work with local or regional resources, such as the Regional Extension Centers (REC), as part of a strategy to reach a broader audience.[48]

  Beyond the agency's electronic outreach efforts, CMS officials indicated that the agency employs various methods, including bi-weekly stakeholder collaboration meetings, in-person training, and print advertisements, to engage covered entities. Another activity officials noted as responsive to stakeholder feedback is the direct mail pilot project that began in August 2014, and which CMS officials said the agency plans to expand in 2015. CMS officials noted that CMS is able to track whether recipients of direct mail have accessed the agency's ICD-10 website. Additionally, CMS officials said that, in 2012, the agency began conducting multiple trainings with the RECs on the ICD-10 transition in partnership with the Office of the National Coordinator for Health Information Technology.

- Promote a greater sense of immediacy. Four stakeholders we contacted recommended that CMS's outreach efforts foster a greater sense of "immediacy" in order to convince covered entities that they should begin preparing for the transition; the amount of time necessary to properly prepare is significant. For example, one stakeholder urged CMS to strengthen its message to providers by

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[48]The Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009, established the REC program, administered by HHS's Office of the National Coordinator for Health Information Technology. RECs received funding to assist providers—in particular, those working in small primary care practices or in critical access hospitals, community health centers, and rural health clinics—in the adoption, implementation, and meaningful use of electronic health record systems.

encouraging providers to conduct specific transition-related activities, such as a systems remediation assessment.

CMS officials noted that the agency has taken steps to modify the types of messages they send covered entities as the transition deadline approaches. After the most recent delay in the transition date, officials said that CMS's messages began highlighting the practical steps covered entities could take to get started with their transition to ICD-10. For example, officials noted that CMS has issued "one year out" messages intended to help covered entities follow a one-year plan to transition to ICD-10, as well as messages that direct covered entities to detailed ICD-10 transition guidance and resource materials. CMS officials said that the agency's messaging in 2015 will continue to focus on encouraging covered entities to begin specific, technical activities, such as by providing guidance on how to conduct end-to-end tests for ICD-10 readiness.

- Communicate Medicare FFS claims submission alternatives. Four stakeholders we contacted expressed concern that providers could face delays in reimbursement if they have problems making changes to their practice management or electronic health record systems to enable the electronic submission of claims with ICD-10 codes by the transition deadline; therefore, they suggested that CMS do more to communicate alternatives for submitting claims.[49]

CMS officials noted that the agency has already made available information on alternatives for claims submissions to covered entities through an MLN Matters article. These alternatives, according to the article, consist of free billing software available from the MACs' websites or MACs' Internet portals if the portal offers claims submissions.[50] In addition, providers and suppliers may submit paper

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[49]Providers may not be able to submit ICD-10 codes by the transition deadline for various reasons including that their vendors, which are not covered entities, have not developed or implemented ICD-10 compliant practice management systems or electronic health record systems, or because providers have not taken the necessary steps within their own practices to prepare for the transition.

[50]See CMS, "Medicare Fee-For-Service (FFS) International Classification of Diseases, 10th Edition (ICD-10) Testing Approach," *MLN Matters*, No. SE1409, revised July 31, 2014.

According to CMS officials, 8 of the 16 MACs currently offer Part B claims submission on their provider Internet portals; durable medical equipment and institutional MACs do not make available claim submission through their provider Internet portals.

claim forms. However, this information is included in an article primarily addressing CMS's Medicare FFS ICD-10 testing approach, and it may not be clear to covered entities that this document also communicates Medicare FFS claim submission alternatives. Officials indicated that CMS plans to publish a claims submission alternative educational product in September 2015, but if the agency learns that providers need the information sooner, they will issue the document earlier.

- Communicate Medicare FFS contingency plans. Four stakeholders we contacted suggested that CMS should make public the agency's Medicare FFS contingency plans that address potential post-transition issues. Two stakeholders suggested that without a contingency plan, covered entities may doubt whether CMS is ready for the transition deadline, and that making such plans public would demonstrate CMS's commitment to the transition date and instill confidence that CMS has a clear strategy for addressing any issues that may arise.

  CMS officials developed a draft contingency plan that outlines the steps CMS will take to address specific issues affecting Medicare FFS claims processing if they were to arise after the transition, but this plan has not been shared with the public. Officials indicated that they do not intend to make the contingency plan public because the information relevant to providers—that is, claims submission alternatives—has already been made available in an MLN article. CMS's contingency plan addresses the agency's plans in the following scenarios: if covered entities are unable to submit ICD-10 codes, if covered entities are submitting incorrect ICD-10 codes, and if CMS's Medicare FFS claims processing systems are unable to accept and correctly process claims. To help prepare in the case of the latter scenario, the plan indicates that the agency would hold an exercise—which occurred in December 2014, according to CMS officials—to simulate the actions that could be taken in such an event. Officials said that if there are issues that occur on or after October 1, 2015, CMS will use its regular communication channels to educate the provider community about what is happening and what, if anything, providers need to do.

Provider Burden. Seven of the 28 stakeholders we contacted expressed concerns that the burden of participating in CMS audits and various other concurrent programs is limiting and will continue to limit health care providers' ability to focus on ICD-10 transition preparedness, and requested that CMS mitigate any additional provider burdens leading up to and following the ICD-10 transition. For example, one stakeholder

suggested that CMS delay implementing any new audits, because the individuals responsible for preparing for the transition to ICD-10 codes are often the same individuals involved in responding to CMS's audit activities. Another stakeholder indicated that a lack of staff is the greatest barrier to a successful ICD-10 transition, as providers are also trying to simultaneously comply with a number of competing health reform priorities, such as the Medicare Electronic Health Records program.

In written responses to us, CMS officials stated that the agency understands the effect new audit activities have on providers. However, officials also indicated that some audits may have the potential to decrease provider burden, and that it would not be appropriate for CMS to delay all new audits. Additionally, while CMS officials did not identify specific actions the agency could take to address stakeholders' concerns about the burden of participating in various other concurrent programs, they noted that the transition to ICD-10 is foundational to advancing health care. Specifically, CMS officials stated that the granularity of ICD-10 codes will improve data capture and data analysis, which can be used to improve patient care, and inform health care delivery and health policy.

Concluding Observations

A successful transition to ICD-10 codes requires every health care provider, clearinghouse, and payer to prepare in advance of the October 1, 2015, transition deadline. CMS has taken multiple steps to help prepare covered entities for the transition, including developing educational materials and conducting outreach, and the majority of the stakeholders we contacted reported that both of those activities have been helpful to preparing covered entities for the ICD-10 transition. With respect to Medicare, CMS reported that the agency's Medicare FFS claims processing systems have been updated to reflect ICD-10 codes, and it is not yet known whether any changes might be necessary based upon the agency's ongoing external testing activities. CMS has also worked with the states to help ensure that their Medicaid systems are ready for the ICD-10 transition, but, in many states, work remains to complete testing by the transition deadline.
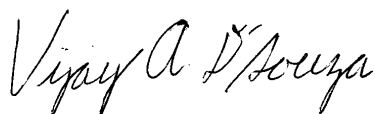
Agency Comments

We provided a draft of this report to HHS for comment. HHS concurred with our findings. In its written comments, reproduced in appendix I, HHS stated that it is committed to helping address stakeholders needs and in working with those that need additional assistance to prepare for the transition. The Department detailed various methods it has used and is using to prepare stakeholders, Medicare FFS claims processing systems, and state Medicaid agencies for the transition.

HHS also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of CMS, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or dsouzav@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

Vijay A. D'Souza
Director, Health Care

Appendix I: Comments from the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

Vijay D'Souza
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Mr. D' Souza:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "International Classification of Diseases: CMS's Efforts to Prepare for the New Version of the Disease and Procedure Codes" (GAO-15-255).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO)
DRAFT REPORT ENTITLED: INTERNATIONAL CLASSIFICATION OF DISEASES:
CMS'S EFFORTS TO PREPARE FOR THE NEW VERSION OF THE DISEASE AND
PROCEDURE CODES (GAO-15-255)**

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity to
review and comment on the Government Accountability Office's (GAO) draft report.

On August 4, 2014, HHS issued a final rule that changed the compliance date for the
International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for
diagnosis coding and the International Classification of Diseases, 10th Revision, Procedure
Coding System (ICD-10-PCS) (collectively, ICD-10) from October 1, 2014 to October 1, 2015.
ICD-10 compliance is mandatory for all Health Insurance Portability and Accountability Act-
covered entities.

HHS has utilized a number of methods throughout the transition to assess stakeholder readiness
and assist all providers, payers, plans, clearinghouses, vendors and other stakeholders in the
transition to ICD-10. In 2011, HHS's contractors interviewed 27 entities representing vendors,
payers, and small physician practices, and surveyed almost 600 entities regarding their awareness
of and preparation for the transition to ICD-10, showing widespread awareness of ICD-10. Since
2011, HHS has instituted a number of methods to gauge industry readiness for the transition,
including regular planning sessions with industry stakeholder groups, 27 focus-group testing
sessions, 84 in-depth telephone interviews with key ICD-10 audiences, and regular reviews of
numerous industry surveys conducted by the health care industry. Considering the rapidly
approaching transition deadline of October 1, 2015, HHS has determined that its limited
resources would be better spent continuing its focus on extensive stakeholder outreach instead of
conducting another survey. As noted in the GAO report, the Centers for Medicare & Medicaid
Services (CMS) continues to use multiple avenues to assess readiness, including feedback from
bi-weekly stakeholder collaboration meetings, training evaluations, focus group testing, and
review of industry surveys.

HHS is committed to helping address stakeholder needs in preparing for the transition to ICD-10
and continues to work with stakeholders that need additional assistance. HHS created the "Road
to 10" program to specifically target small physician practices, which were identified as needing
additional support in the transition to ICD-10. The Road to 10 site features physician
perspectives, benefits of ICD-10, and medical specialty training videos focused on ICD-10
readiness steps and improving clinical documentation to support the use of ICD-10 codes. The
website also provides a customizable action plan based on several criteria: specialty, practice
size, and current level of readiness for ICD-10 implementation. HHS has also conducted over 75
on-site trainings for small physician practices in 25 states with additional trainings scheduled in
2015. HHS works with local groups to provide trainings in all locations requested by
stakeholders. In addition, HHS has piloted a direct mail project in four states to communicate
important information with those that cannot easily access online resources. HHS will expand
the direct mail campaign to other areas in 2015.

HHS utilizes multiple mechanisms and channels for communicating information about the
transition to ICD-10. HHS is implementing national, state, and local outreach efforts through a
strong industry partnership program that focuses on communication, collaboration, and
education. HHS reaches out to all stakeholders – providers, payers, clearinghouses, associations,

and vendors – directly, through listening sessions, planning meetings, free training, webinars, focus group research, social media, paid media, and other direct communications, as well as indirectly, through stakeholder groups and industry associations.

Currently, CMS's Medicare fee-for-service (FFS) claims processing systems are completely updated to accept ICD-10 codes and undergo quarterly testing to confirm readiness. In addition, acknowledgement testing with providers has not identified any issues with the Medicare FFS claims systems. HHS has conducted two highlighted weeks of acknowledgement testing (March 3-7, 2014 and November 17-21, 2014) with real-time help desk support in addition to on-going acknowledgement testing in which providers, suppliers, billing companies, and clearinghouses can submit claims at any time up to the October 1, 2015 implementation date. HHS plans to host two more acknowledgement testing weeks (March 2-6 and June 1-5, 2015) and three end-to-end testing weeks (January 26-30, April 27-May 1, and July 20-24, 2015) prior to the compliance date for ICD-10.

With respect to Medicaid, states have reported that they will be able to perform all critical activities prior to October 1, 2015 to ensure their compliance with ICD-10 on October 1, 2015. HHS is working with states to obtain additional information in order to validate that the critical activities will be met. In addition, HHS will work with states to develop mitigation plans. State Medicaid Agencies are required to conduct end-to-end testing to prepare for the ICD-10 transition and report their findings to HHS.

HHS has also developed an added layer of testing, through its State Testing Program that will complement the individual end-to-end testing for the states. The State Testing Program is a comprehensive, integrated testing solution that utilizes a web-based platform and secure portal that allows states and providers to collaborate on test strategies and test plans. The program provides states with 2,750 testing scenarios and the capability to develop custom scenarios. The states also receive assistance in setting up a test environment that supports connectivity, testing execution, and test results analysis. The tool helps states identify the high priority providers to test with based on provider claims volume, billing dollars, and risk factors. HHS has also conducted 62 onsite ICD-10 technical assistance and training visits in 43 states as well as the District of Columbia and two territories. Future trainings after January 2015 will be for those states that need additional assistance and one territory that requested onsite training.

Appendix II: GAO Contacts and Staff Acknowledgments

GAO Contact	Vijay A. D'Souza, (202) 512-7114 or dsouzav@gao.gov
Staff Acknowledgments	In addition to the contact named above, Gregory Giusto, Assistant Director; Nick Bartine; Shannon Legeer; Drew Long; and Jennifer Whitworth made key contributions to this report.