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on behalf of the

American Urological Association

Written Testimony for the Record

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Hearing Entitled

"Examining ICD-10 Implementation"

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Chairman Pitts, Ranking Member Green, members of the Subcommittee on Health, and honored guests, my name is Dr. William Jefferson Terry and I am testifying in front of you today as a member of the American Urological Association and as a practicing urologist in Mobile, Alabama at Urology & Oncology Specialists, PC. The AUA would like to thank the House Energy and Commerce Subcommittee on Health for taking an in-depth look at the implementation of ICD-10. The AUA appreciates the opportunity to share our views related to the health care classification system of diagnostic codes, including the administrative and financial burden, implementation preparation, and overall uncertainty about the impact ICD-10 will have on the practice of medicine.

For your reference, the AUA was founded in 1902 and is the premier professional association for the advancement of urologic patient care. The AUA works to ensure that its more than 18,000 members are current on the latest research and practices in urology. The AUA also pursues its mission of fostering the highest standards of urologic care by providing a wide range of services—including publications, research, the Annual Meeting, continuing medical education (CME) and the formulation of health policy. The AUA is a member organization of the Alliance of Specialty Medicine, and last Congress I moderated an Alliance physician roundtable which included representatives from the Centers for Medicare and Medicaid Service (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) on the subject of ICD-10 implementation due to concerns by many physician organizations regarding this matter.

The AUA enters the debate on ICD-10 as an advocate for patients and physicians. Our organization and its members are vested in the preservation of the all-important patient-physician relationship. From a personal standpoint, I have a son who is a physician. In addition, I have recently entered the medical system as a cancer patient, and I worry about the impact of ICD-10 on my cancer care providers, as I do not want to see them retire early from the medical profession out of frustration.

As you hear testimony today from each of the witnesses, I hope that you will keep in mind the concerns of practicing physicians – particularly those in small practices – balanced with *proven* advantages of ICD-10 on direct patient care and weighed against the consequences of a poorly executed implementation. This is what I always discuss with my patients when sharing in the decision on various treatment options; “Do the benefits outweigh the risks?”

The International Classification of Diseases (ICD) is designed to promote international comparability in the collection, processing, classification, and presentation of mortality statistics, and for the purpose of gathering statistical and epidemiological data. ICD provides a system of diagnostic codes for classifying diseases, including nuanced classifications of a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. The ICD Clinical Modification 9th revision (ICD-9-CM) is a unique system for use specifically in the United States. ICD-9-CM Volumes 1 and 2 are used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office utilization, whereas Volume 3 is used in assigning codes associated with inpatient procedures. The United States is the only country in the world that has modified the classification system for use in payment and reimbursement programs. Physicians and other outpatient facilities use the American Medical Association's (AMA) Current Procedural Terminology (CPT) to report outpatient procedures, such as doctor's office visits and other professional health care services. The CPT system is actually designed for and used to submit the physician's bill for services.

ICD-10-CM is the clinical modification (CM) to the 10th revision of the ICD classification system. ICD-10 has been used in the United States for reporting of mortality since January 1, 1999, and its clinical modification, ICD-10-CM, is planned as the replacement for ICD-9-CM, volumes 1 and 2 beginning October 1, 2015. On this date, physicians will be required to use the new code set to report diagnoses, but will continue to use CPT to report professional services.

Our present ICD-9 system has approximately 13,000 codes whereas ICD-10-CM has 68,000 codes. The United States is the only country to use all 68,000 codes, whereas most countries use only about one fifth the number of codes. We are hopeful that most physician practices will only be required to use a relatively small proportion of the diagnostic code set, but that remains to be seen.

There are significant differences between the current ICD-9-CM and the new ICD-10-CM classification system. ICD-9 codes are mostly numeric and have 3 to 5 digits. ICD-10 codes are alphanumeric and contain 3 to 7 characters. ICD-10 is significantly more descriptive with one-to-many matches in many instances.

ICD-9-CM is considered to be outdated because its structure is limited, it lacks specificity and there is no more room to add new diagnosis codes in certain areas. ICD-10-CM will increase specificity, allow for reporting of laterality and provide a new coding system with new rules for reporting diagnosis coding. Some diagnosis codes will have one to one correlation between ICD-9-CM to ICD-10-CM, where others will have a one-to-many correlation. In addition, there are quite a few areas that have been expanded to report right vs. left, unilateral vs. bilateral, male vs. female, as well as etiology, severity and anatomic location. There is also a new requirement to report whether the encounter is initial, subsequent, or a sequelae and the cause of the condition.

The AUA worked with key stakeholders, including the National Centers for Health Statistics of the Centers for Disease Control and Prevention (CDC), to capture urologic diagnosis

codes that were either inaccurate or lacking from the initial ICD-10-CM classification system**.** More than 10 sections of the new code set required additional revisions. Unfortunately, these important revisions will not take effect until October 1, 2016, one year after the current implementation deadline. The AUA appreciated the opportunity to work with agency staff to address those issues.

It is estimated that physicians should plan on a 3-4 percent increased time (average) per patient encounter merely for documentation of the correct ICD-10 code choice. While there will be no foreseeable change for many patients, for others there could be a significant amount of time documenting and choosing codes. There are 250 codes just for Diabetes alone. Those who best understand ICD-10 and who are most prepared will see the lesser end of this increase, while those unprepared will have a tremendous stress placed upon them and their practices.

The main reason for the reduced productivity lies in the fact that ICD-10 is significantly more granular, requiring enhanced documentation. In addition, the coding guidelines associated with the new system are more complex. Physicians will need to be much more specific when documenting etiology (of certain conditions), laterality (of certain conditions), location of the process (certain conditions), visit number (initial, subsequent, or sequelae of the condition mainly for trauma and external injury), among other items. There are also exclusions and sequencing rules that need to be understood. Physicians need to understand the ICD-10 coding construct for successful code choice. Those who do not understand will fail to document correctly, making it more difficult to code correctly, thus delaying or preventing appropriate and timely reimbursement.

Proponents of the ICD-10 transition tout the classification system's increased granularity as a benefit. That is, improved clinical data will lead to better-informed clinical decisions and improved clinical quality. These potential benefits have not been founded in any recognized medical literature or research study. However, the costs of the conversion have been studied and well-documented, and are a major issue for physicians and their staff who are already facing tremendous pressure to comply with a myriad of complex federally-driven initiatives, such as the Electronic Health Record (EHR) Incentive Program, the Physician Quality Reporting System (PQRS) program, the Value-based Payment Modifier (VM), not to mention the annual threat of reimbursement cuts due to the flawed Sustainable Growth Rate (SGR) formula, the 2% sequestration cuts, and CMS' other programs, including multiple audit programs. And, now we face a very costly, unfunded mandate in moving to ICD-10.

Physicians are overwhelmed with the tsunami of regulations that have significantly increased the volume of work for physicians and their staff, many of which have questionable value to improving the quality of care provided to patients. Many physician practices (especially the rural one- or two-physician practices) do not have the time, money, or expertise to follow and comply with the mounting regulatory challenges, which is why many are considering early retirement or opting out of the Medicare program. Given current physician workforce and staffing challenges, this is an important consideration. Should physicians leave the medical professional due to the increased financial and administrative burdens imposed by the federal government, countless numbers of patients could be left without a provider. Even for practices who sustain the implementation, they may be forced to reduce their clinical schedules during the

transition period, making it difficult for patients to access and receive important medical care.

Over the past several years, the AUA has worked diligently to educate its members on the move to ICD-10, developing tools to help urologists manage the task ahead, while also assisting them with other practice management issues. CMS and other coding-focused entities have also developed tools and educational materials to help ease learning and lessen the burden of the forthcoming transition, however, these tools are not enough to help most convert to the new system by October 1, 2015. In fact, most of them have been designed with primary care practices in mind, with very little being available for specialty practices like mine. In addition, CMS' General Equivalence Mappings (GEMs), which map ICD-9 to ICD-10 codes, are not a direct "cross-walk" between the two classification systems. This means urologists and their staff will have to learn the new system from the "ground up." Learning a new coding system, even for our most adept physicians and knowledgeable coding and billing staff, is a significant and burdensome challenge.

CMS and the coding industry have said that it can take a year to adequately prepare for this transition. If we must transition, ICD-10 implementation should be incremental – carried out over 2-3 years, which we believe CMS and other health insurers' administrative systems are capable of. In fact, all insurers will run dual-systems for some time period given the lag between when claims must be filed and processed. A hastily implemented transition could prompt serious unintended consequences and be detrimental for all stakeholders, including patients.

I also have serious concerns with the potential cash flow nightmare that physicians will

face while transitioning to ICD-10. There are significant costs associated with upgrading hardware, software, and training personnel for the massive conversion to ICD-10. An independent study by Nachimson Advisors one year ago showed the cost of conversion to small practices could range from $50,000 to $250,000 depending on the charges from various system vendors coupled with lost productivity and potential denied claims. This figure for larger practices of 100 physicians or more can vary from $2 – 8 million.[1]

ICD-10 implementation consultants as well as CMS have also recommended that practices reserve enough money to cover medical supplies, payroll, rent, and everything else required to keep the practice operational for three to six months. That will be especially difficult for small practices that may not have the funds on hand and will need to work with a bank to secure loans. My urology practice of 8 physicians needs close to $800,000 to run each month and my banker will not give me a line of credit for 3 - 6 months because it would be an unsecured line of credit. Since we rent our office and own very little, if we did go out of business after 1 – 2 months it is more than likely that the bank could not be repaid.

While the reduction in cash flow will be most pronounced for those who are least prepared, it will still affect those who are well prepared, albeit less. There are many steps involved between when a physician provides a service and when he gets paid. The physician can document and code perfectly, however, if anything goes wrong in what I refer to as the massive "payment pyramid" the physician could potentially go unreimbursed for care provided. In fact,

[1] "The Cost of Implementing ICD-10 for Physician Practices -- Updating the 2008 Nachimson Advisors Study", A Report to the American Medical Association, Nachimson Advisors, LLC, February 12, 2014.

while ICD-10 proponents tell us that the new system has the potential to make payment more precise, given the more robust and accurate documentation of services, the expense in doing so will likely result in higher costs to the physician practice, as well as payers and patients. We also worry that providers who aren't as skilled and rigorous in documenting services under ICD-10 will receive lower payments.

CMS admits that, "Lack of reimbursement could force practices to shut down, making medical services inaccessible to patients and/or forcing physicians to ask patients to pay up front, out-of-pocket, for medical services, which, aside from being barred by the terms of some insurance programs, would be extraordinarily burdensome to patients."[2]

Those who believe that ICD-10 is merely an expansion of ICD-9, or those who believe that they can just search for a code on their EHR or with a search tool will be the ones who will be most affected. Those who believe that they will just use the "unspecified" codes for each condition will be the ones with the most delays in payment, request for records, and denials. By looking at the ICD-10 code set, I see very rare cases where "unspecified" codes can be correctly used in ICD-10, as the coding system is so comprehensive. I could see a situation where "unspecified" codes are denied outright and records are requested by payers to see if the patient truly warranted an "unspecified" code, or if the provider merely didn't take the time to learn the specificity needed to code correctly and chose the "unspecified" code out of convenience or lack of education. CMS says that after ICD-10 implementation, physicians can expect changes in

[2] "A Change to the Compliance Date for ICD-10-CM and ICD-10-PCS Medical Data Code Sets, Proposed Rule." Federal Register 77:74 (17 April 2012) p. 22989.

payers' prior authorizations and approvals as they refine medical policies. Physicians may also see a significant increase in denials as a result of coding challenges. Audits of all types will increase in depth and breadth, including Recovery Audits. After the transition to ICD-10, the specificity and detailed information levels will result in greater documentation scrutiny. This means the physician is less likely to be paid for services provided to patients.[3]

We are also concerned with the limited amount of testing to determine industry readiness. CMS is in the midst of conducting "end-to-end" testing with physicians, but it will not be completed until a few short weeks before the October 1 deadline. In addition, and given testing is primarily being conducted by volunteers, we also worry the results will not paint an accurate picture of the current state of provider readiness. A survey conducted by the Medical Group Management Association (MGMA) found less than 10 percent of practices have made significant progress to prepare for the transition. It is my sense that practices that volunteer are more likely to be prepared, and will not be reflective of the broader physician community. CMS must release the results of its ICD-10 testing activities and practice demographics for its volunteers, including practice and staffing size, specialty, and health system affiliations. CMS should also reveal details of its contingency plan, given the strong possibility that many providers will not be ready to make the transition on October 1.

No EHR system, professional coder/biller or online ICD-10 search tool can prepare any physician for the massive change in moving from ICD-9 to ICD-10. A successful transition will take a tremendous amount of work related to EHRs, practice management, clearinghouses,

[3] "ICD-10 Implementation Guide for Small and Medium Practices", CMS 2012

payers, provider education, coder/biller education, changing super bills, changing documentation patterns, and understanding the nuances of ICD-10.

Simply put, physicians are not prepared for this change. Given the annual threat of reductions in Medicare reimbursements, the burden of participating in multiple CMS quality improvement programs and adopting health information technologies to avoid steep financial penalties, and the expense of ensuring compliance with Medicare's ever changing requirements and multiple audit programs, physicians and their staff simply do not have the time to focus on transitioning to ICD-10. Physicians are growing exhausted; ICD-10 is just another expensive distraction with little demonstrated value to improving direct patient care.

Studies showed that 25% of hospitals and health systems were not confident in their ability to implement ICD-10 just prior to the last delay. If we assume a conservative estimate, suggesting that 10% of physicians will not survive the implementation, that means thousands of patients will have to find a new doctor, an already challenging task given current workforce and staffing issues.

Our focus today should not be centered solely on the financial investment made by large health insurers, health systems, and other entities on preparing for this transition. Rather, we should be honing all of our collective efforts to improve the quality and value of healthcare in this country. To accomplish this, the federal government should promote and enable a practice environment where physicians and other healthcare professionals can devote all of their energies on direct patient care, achieving a healthy America without undue burden and distraction.

To that end, I urge Congress to delay implementation of the ICD-10 code set and appoint a committee to better study the "risks and benefits." If a delay is not possible, I urge you to consider legislating a dual ICD-9/ICD-10 option so that physicians will have time to transition to the new coding system especially those nearing retirement or those with a demonstrable hardship that limits their ability to adopt ICD-10 by the deadline.

Thank you for your commitment and leadership on this important issue to urologists and my colleagues in medicine. It is important to urologists and the medical profession, and it is important to all patients not to lose their physicians from a government mandate that is not well thought out. ICD-11 is at least 5 years away so we need a policy for appropriate coding transitions in order to avoid this problem again in the future. I am happy to answer any questions or follow up with additional information about the challenge ICD-10 poses to the practice of medicine.