



AMERICAN COLLEGE OF PHYSICIANS
INTERNAL MEDICINE | *Doctors for Adults*

October 21, 2008

The Honorable Michael O. Leavitt
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

**Re: The Health Insurance Portability and Accountability Act (HIPAA)
Administrative Simplification: Modification to Medical Data Code Set
Standards to Adopt ICD-10-CM and ICD-10-PCS; Proposed Rule; CMS-
0013-P**

Dear Secretary Leavitt:

The American College of Physicians (ACP), representing over 126,000 internists and students, appreciates the opportunity to comment on the proposed rule *HIPAA Administrative Simplification: Modification to Medical Data Code Set Standards to Adopt ICD-10CM and ICD-10-PCS*. Our comments will focus on the proposed adoption of ICD-10-CM, the diagnosis code portion of the set relevant to the ambulatory setting.

ACP Primary Recommendation

The College urges the Centers for Medicare and Medicaid Services (CMS) to suspend plans to adopt ICD-10-CM, the diagnosis code portion of the ICD-10 set, for physicians and other outpatient entities. Adoption of this diagnosis code set in the ambulatory setting is unwarranted as the collective costs far out-weigh the benefits. Our comments primarily address the costs to physicians. While other physician organizations and other stakeholders will make a similar case, we believe that our emphasis on the especially detrimental affect it would have on small primary care practices will significantly enhance the debate. The burden associated with implementing ICD-10-CM is likely to exacerbate the crisis in the primary care workforce.

CMS, as part of the proposed rule, includes an impact analysis of the effect of ICD-10 adoption on the healthcare community—including physicians—based on somewhat dated studies conducted by the Rand Corporation (2004)ⁱ and the Robert E. Nolan Company (2003)ⁱⁱ. The College believes that the estimates made by CMS based on these analyses substantially

ⁱ Rand. The Costs and Benefits of Moving of Moving to the ICD-10 Code Sets. Accessed at http://www.rand.org/pubs/technical_reports/2004/RAND-TR132.pdf on 14 October 2008

ⁱⁱ Robert E Nolan Co. Replacing ICD-9-CM with ICD-10-CM and ICD-10-PCS, Challenges, Estimated Costs and Potential Benefits. Accessed at http://www.renolan.com/healthcare/icd10study_1003.pdf on 14 October 2008.

underestimate the impact of adoption on providers. More recently, Nachimson Advisors LLC (2008)ⁱⁱⁱ released an analysis of the impact of implementing ICD-10 on physician practices—an independent study that ACP helped to fund. The College believes that the Nachimson Advisors study more accurately captures the overall impact of adoption. This study reflects that substantial changes would be required throughout the business operations of the practice setting with significant added costs—costs that refute the CMS estimates—accruing in the following six areas:

- staff education and training on the new code set;
- the need for business-process analysis of health plan contracts, coverage determinations, and documentation;
- required changes to superbills;
- required health information technology (HIT) changes and updates;
- increased documentation costs due to the increased detail of the new code set; and
- cash flow disruption resulting from the transition to this new system.

Nachimson Advisors, LLC estimates that this change to ICD-10-CM would cost the typical “small” practice comprising 3 physicians approximately \$83,000. In addition to these one-time costs, it is estimated that there will be ongoing additional costs on account that the physician’s workload will increase by 3-4 % as a result of the increased effort involved in selecting the appropriate diagnosis code under the new, expanded code.

The administrative changes and related costs of ICD-10 adoption at this time will place a significant burden on internal medicine and all other physicians; with the burden especially acute for primary care physicians. This is at a time when physician practices—small primary care practices--are already struggling to meet:

- other regulatory requirements (e.g. other HIPAA related initiatives including implementation of the National Provider Indicator (NPI) and the upcoming adoption of the 5010 transaction standards);
- calls for increased adoption of HIT (e.g. e-prescribing and interoperable electronic health records (EHR) systems) including the recently passed Medicare e-prescribing bonus that transitions into a payment reduction; and
- expectations to participate in various pay-for-quality initiatives such as the Medicare Physician Quality Reporting Initiative (PQRI).

The College strongly believes that the increased administrative burden and costs related to adoption of ICD-10-CM will interfere with physicians’ ability to meet regulatory requirements, slow if not permanently delay their adoption of HIT, and challenge their ability to engage in other quality improvement efforts. Further, these unintended but nearly certain consequences will exacerbate the crisis in primary care that this country is beginning to experience.

ⁱⁱⁱ Nachimson Advisors, LLC. The Impact of Implementing ICD-10 on Physician Practices and Clinical Laboratories. Accessed at <http://nachimsonadvisors.com/Documents/ICD-10%20Impacts%20on%20Providers.pdf> on 14 October 2008

Imposing ICD-10 now will have a disastrous impact on primary care practice at precisely the time that the literature is demonstrating value of primary care and policymakers are looking for ways to stem the tide of the eroding base. The Medicare Payment Advisory Committee (MedPAC), in its *2008 Report to Congress*^{iv}, expressed concern over the decreasing primary care workforce and the resulting negative affect on access to care deemed essential for any high-functioning healthcare delivery system. The number of new students entering into primary care is decreasing^{v vi} and physicians who have chosen the field are disproportionately leaving compared to other specialties^{vii}. This is in contrast to a projected need for an expanded primary care workforce to meet the needs of an aging “baby boomer” cohort.^{viii} Factors contributing to this decreased interest in primary care include the administrative burdens related to primary care practice and the reduced compensation related to other areas of medicine^{ix} --two conditions that will be negatively impacted by ICD-10 adoption at this time.

CMS outlines specific projected benefits for the proposed adoption including more accurate payments, fewer rejected claims, fewer improper claims, better understanding of new procedures, improved disease management, better understanding of health conditions and health care outcomes and harmonization of disease monitoring and reporting world-wide. We note that many of these projected benefits refer to improvements in the procedure code classification system (ICD-10-PCS) and are not directly tied to ICD-10-CM adoption.

The College also challenges the assumptions pertaining to the CMS-projected benefits that relate to ICD-10-CM. Required use of ICD-10 is likely to increase payment delays and denials. While CMS and other payers have to indicate how ICD-10 will be used to justify payments, we assume that the payment policy that requires a diagnosis code to be reported to its highest level of specificity will continue. The increased complexity inherent in ICD-10 will increase the challenges physicians face in receiving payment for their services. This will be especially troublesome in the short-term but will remain problematic even as physicians become more familiar with the new, more detailed code set. Further, proposed benefits such as improved disease management and a better understanding of health conditions (through improved research capabilities stemming from increased detail available in the code set) are uncertain based on literature review and may require adoption of a standard clinical vocabulary (e.g. SNOMED-CT)

^{iv} Medicare Payment Advisory Committee (MedPAC). Promoting primary care. Report To Congress: Reforming the Delivery System. June, 2008. Accessed at http://www.medpac.gov/documents/Jun08_EntireReport.pdf on 14 October 2008

^v Popkave, CG. Research Associate, Office of Research, Planning, and Evaluation, American College of Physicians. Personal Communication. February 2006. ITE Exam Survey Data.

^{vi} Hauser KE, Durning SJ, Kernan WN, et. al. Factors associated with medical students' career choices regarding internal medicine. JAMA. 2008 Sep 10;300(10):1154-64.

^{vii} Lipner RS, Bylsma WH, Arnold GK, Fortna GS, Tooker J, Cassel CK. Who is maintaining certification in internal medicine—and why? A national survey 10 years after initial certification. Ann Intern Med. 2005;144:29-36

^{viii} US. Department of Health and Human Services. Changing Demographics: Implications for Physicians, Nurses, and Other Health Workers. Accessed at <http://bhpr.hrsa.gov/healthworkforce/reports/changingdemo/default.htm> on 14 October 2008

^{ix} Hauser KE, Durning SJ, Kernan WN, et. al. Factors associated with medical students' career choices regarding internal medicine. JAMA. 2008 Sep 10;300(10):1154-64.

to be achieved^x Providing more diagnostic code options is not guaranteed to generate better data or patient care.

Alternative Options for Further Exploration

In the proposed rule, CMS identifies problems with the current ICD-9 code set and discusses benefits of moving to ICD-10. Recognizing these challenges and opportunities, we offer alternative options aimed at reaching the goal of an improved healthcare coding classification set in a more effective and efficient manner. CMS should work with stakeholders to explore these options further as they have the potential to significantly reduce or avoid the hazards associated with ICD-10-CM adoption. These options may not be mutually exclusive.

Electronic Health Record Adoption as Facilitator Option

Wide-spread interoperable EHR adoption would greatly facilitate the ease of transition to a new diagnosis classification system. It would significantly reduce required administrative burden and the cost of this adoption. The EHR systems implemented would have to be compatible with the new classification system and this could be accomplished over time through coordination with the Certification Commission for Health Information Technology (CCHIT) approval process. Further, the inclusion in these certified EHR systems of a universal standard clinical vocabulary mapped to the new diagnosis classification system will facilitate the obtaining of the benefits of improved healthcare research and a better understanding of health conditions. Mapping a standard clinical vocabulary to the diagnosis classification system will help to minimize the need for the physician to be directly involved in selecting the appropriate diagnosis code(s) for each encounter.

CMS could indicate that adoption of ICD-10-CM (or a similar diagnostic classification system) by physicians and other outpatient-related entities would be tied to EHR adoption to promote software vendors to ensure that their products were equipped with functionality tied to the new diagnosis code set—and that they meet CCHIT requirements. The agency could require use of the new diagnosis code set once a super-majority of these providers/entities have adopted a CCHIT approved EMR system that is compatible with the classification system and contains a universal standard clinical vocabulary mapped to the new classification system. The agency could provide periodic updates on the physician adoption of capable EHR products to provide an estimate of the time until use of the new diagnosis code set is required.

Increased Payment and Other Incentives Aimed at Primary Care

ACP and numerous others, including key policymakers, such as MedPAC^{xi}, recognize the declining interest in primary care, its collective value to the healthcare system, and recommend measures to support it. CMS could and should take steps to improve the primary care

^x Robert E Nolan Co. Replacing ICD-9-CM with ICD-10-CM and ICD-10-PCS, Challenges, Estimated Costs and Potential Benefits. Accessed at http://www.renolan.com/healthcare/icd10study_1003.pdf on 14 October 2008.

^{xi} Medicare Payment Advisory Committee (MedPAC). Promoting primary care. Report To Congress: Reforming the Delivery System. June, 2008. Accessed at http://www.medpac.gov/documents/Jun08_EntireReport.pdf on 14 October 2008

environment using its regulatory authority and through support of Congressional initiatives. The agency has the ability to:

- make adjustments to the Medicare payment methodology that are fair and would benefit payments for primary care services;
- make separate Medicare payment for services—that are currently described through procedure codes—that promote better coordination of patient care;
- provide further positive incentives to improve quality and acquire and use HIT; and
- decrease the Medicare-imposed administrative burden that impacts all physicians but disproportionately affects primary care, such as by streamlining prior authorization and appeals related to Part D coverage of prescription drugs.

Improving the primary care environment will make it more feasible for small primary care practices to implement ICD-10-CM or some other expanded diagnosis code set.

Other Potential Options

CMS could consider handling ICD-10-CM differently from ICD-10-PCS. For example, introduce ICD-10-PCS at this time, but suspend adoption of ICD-10-CM until other criteria are satisfied. This may be feasible as it our understanding that hospitals support ICD-10 for input procedure coding. Further, while limited space in the ICD-9 classification system hierarchy is an expressed concern, this applies primarily to the ICD-9 procedure code set. We urge CMS to consult the most directly affected stakeholders when considering this option.

CMS could consider expanding ICD-9-CM and/or scaling back ICD-10-CM to include only the most essential elements. The rule states that ICD-10-CM contains 68,000 diagnosis codes. A previously Department of Health and Human Services estimate put the number of diagnosis codes at 120,000. While we are confounded by the lack of definitive code count for ICD-10-CM, it nevertheless will represent a significant increase in the number of diagnosis codes from which physicians must select. Using the minimal number of codes that are effective should be a priority.

Extended Implementation Timeline Option

At an absolute minimum, the CMS should modify/lengthen the aggressive implementation timeline described in the proposed rule. It would be reasonable for CMS to follow a timeline similar to that recommended by its expert advisory body the National Committee on Vital and Health Statistics^{xii} such as:

1. Providing at least 60 months to adopt and implement both HIPAA 5010 transaction standards (which are required for ICD-10 implementation) and ICD-10-CM from the date of publication of the 5010 final rule; and
2. Requiring adoption of ICD-10-CM no sooner than 2 years following 5010 industry readiness levels reaching at least 95 percent.

^{xii} National Committee on Vital and Health Statistics. Letter to Secretary Leavitt. September 26, 2007. Accessed at <http://www.ncvhs.hhs.gov/>

This timetable modification will provide all relevant stakeholders, including physicians, with a more reasonable amount of time to implement the substantial “on-line” testing, training, workflow, and system changes that will be required with both 5010 and ICD-10 adoption. This modified timetable is also consistent with publicly-announced recommendations made by members of the payer community (e.g. Blue Cross Blue Shield^{xiii}, AHIP^{xiv}) and a number of medical specialty and subspecialty societies^{xv}. Note that implementation of this lengthened timetable **alone** still contains the risk of significant, unintended negative effects on the primary care workforce due to the increased administrative burden and costs related to the ICD-10 adoption.

The College encourages CMS to seriously consider the potential negative effects of implementing ICD-10 adoption as defined in this proposed rule on physicians, especially those in small and/or primary care practices, and the broader community involved in healthcare delivery and its related functions. If CMS cannot be dissuaded from moving forward with ICD-10-CM implementation, a more deliberate approach towards implementing an expanded diagnosis code classification system that addresses issue stated in this letter is imperative. Please contact Neil Kirschner at 202-261-4535 or nkirschner@acponline.org if you have any questions regarding these comments.

Respectfully,



Yul Ejnes, MD, FACP
Chair, Medical Service Committee

^{xiii} Press release. Accessed at <http://www.bcbs.com/news/press/> on 14 October 2008

^{xiv} AMEDNEWS.COM. Don't rush change to IDC codes. Accessed at <http://www.ama-assn.org/amednews/2008/10/06/edsa1006.htm> on 14 October 2008

^{xv} Inside CMS. Coalition refutes CMS' ICD-10 cost estimates, calls for a delay. Accessed at http://www.insidehealthpolicy.com/secure/health_docnum.asp?f=health_2001.ask&docnum=10152008_refutes&DOCID=10152008_refutes on 16 October 2008