



JUL - 6 2015

Administrator
Washington, DC 20201

The Honorable Kevin Brady
Chairman
Subcommittee on Health
Ways and Means Committee
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter regarding the implementation of the International Classification of Diseases, 10th Revision, Clinical Modification and the International Classification of Diseases, 10th Revision, Procedure Coding System (collectively, ICD-10). The Centers for Medicare & Medicaid Services (CMS) has made excellent progress on ICD-10 and we are on track to implement ICD-10 on October 1, 2015. CMS's Medicare Fee-For-Service (FFS) claims processing systems are ready for the compliance date of October 1, 2015. We will continue to test our systems with each quarterly release to ensure ICD-10 readiness. In April, we completed the second end-to-end testing week with providers – professional and hospitals, with another planned for later this summer. Extensive efforts are being made to reach out to providers to make sure they are ready. CMS has collaborated with physicians and other industry stakeholders to create tailored training and tools specifically to help physicians and their staff prepare for the ICD-10 transition.

Recognizing that health care providers need help with the transition, CMS and the American Medical Association are announcing efforts to continue to help physicians get ready ahead of the October 1 deadline. In response to requests from the provider community, CMS is releasing additional guidance below that will allow for flexibility in the claims auditing and quality reporting process as the medical community gains experience using the new ICD-10 code set.

- For 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule through either automated medical review or complex medical record review based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a code from the right family. However, a valid ICD-10 code will be required on all claims starting on October 1, 2015.
- For all quality reporting completed for program year 2015 Medicare clinical quality data review contractors will not subject physicians or other Eligible Professionals (EP) to the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM), or Meaningful Use (MU) penalty during primary source verification or auditing related to the additional specificity of the ICD-10 diagnosis code, as long as the physician/EP used

a code from the correct family of codes. Furthermore, an EP will not be subjected to a penalty if CMS experiences difficulty calculating the quality scores for PQRS, VBM, or MU due to the transition to ICD-10 codes.

CMS will not deny any informal review request based on 2015 quality measures if it is found that the EP submitted the requisite number/type of measures and appropriate domains on the specified number/percentage of patients if the EP's only error(s) is/are related to the specificity of the ICD-10 diagnosis code (as long as the physician/EP used a code from the correct family of codes).

- CMS will set up a communication and collaboration center for monitoring the implementation of ICD-10. This center will quickly identify and initiate resolution of issues that arise as a result of the transition to ICD-10.
- CMS will name an ICD-10 Ombudsman to help receive and triage physician and provider issues.

In your letter, you requested that we make public any contingency plan, for how Medicare will process claims in the event that CMS is unable to process ICD-10 diagnosis codes on October 1, 2015. We have developed a contingency plan which outlines the steps CMS will take to monitor, assess and address issues affecting Medicare FFS claims processing if they were to arise after the transition. The contingency plan is intended as an internal risk mitigation plan specifying CMS action should certain technical situations arise. The plan addresses the Agency's response 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. CMS has already publicly released in other formats the parts of the contingency plan relevant to providers, including claims submission alternatives. The following claims submission alternatives are available for providers who are unable to submit claims with ICD-10 diagnosis codes due to problems with the provider's system. Each of these requires that the physician be able to code in ICD-10:

- Free billing software that can be downloaded at any time from every MAC;
- In about half of the MAC jurisdictions, providers can submit claims through a MAC provider internet portal; and
- Permitting small providers to submit paper claims if the requirements of section 1862(h) are met.

CMS is using every opportunity to help providers prepare for the ICD-10 transition and inform them of their options should they not be ready as of the mandated compliance date. If providers learn through testing that their systems will not be ready in time, we want them to know what their contingency options will be so that they can exercise the options early. CMS will continue to reinforce this information regularly as the compliance date draws near.

Additionally, you requested that we indicate whether claims must include the ICD-10 diagnosis code with the highest level of specificity immediately upon the October 1, 2015 effective date, or whether a clinically accurate but less granular code will be accepted. In addition to the audit flexibility regarding code specificity CMS just announced, CMS has issued guidance on the use of unspecified codes for Medicare FFS claims. In ICD-9-CM and ICD-10-CM, signs/symptoms and unspecified codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, in some instances signs/symptoms or unspecified codes are the best choice to accurately reflect the health care encounter. Each health care encounter should be coded to the level of certainty known for that encounter. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined but the specific type has not been determined). In fact, unspecified codes should be reported when such codes most accurately reflect what is known.

You also asked that these efforts be incorporated into anti-fraud, waste, and abuse efforts so as not to increase vulnerabilities. In preparation for the ICD-10 transition, CMS has conducted a comprehensive analysis to ensure the Fraud Prevention System, as well as its underlying model and edit components, is equipped to mitigate any potential vulnerabilities that arise from or during the transition. As part of this analysis, CMS specifically:

- Reviewed each model and edit currently running in production to determine applicable ICD-10 impacts/updates;
- Reviewed all potential/scheduled models and edits to determine applicable ICD-10 impacts/updates; and
- Ensured any edits implemented after 6/1/15 included both ICD-9 and ICD-10 codes.

The ICD-10 impacts for existing edits will be updated prior to the transition this fall. While no other active edit has a diagnosis component, all future edits will cover both ICD-9 and ICD-10.

CMS has also researched several new models to identify outliers and prevent improper payments to use as a baseline for developing and updating future models. A multi-phased approach will be employed to carefully transition to ICD-10 claims analysis. As historic data accumulates, it will allow us to identify thresholds and create true predictive models.

As indicated above, CMS has worked to ensure our models and edits take into account any changes from ICD-9 to ICD-10. As the history of ICD-10 codes submitted evolves, CMS will continually update our models, edits, and analytic techniques. As is currently our practice, CMS will continue to engage teams of policy, subject matter, medical and analytic experts as indicated to address specific vulnerabilities.

Your letter also recommended that CMS expand its voluntary "end to end testing" beyond the current 2,500 providers. CMS is conducting an unprecedented level of testing to prepare

providers for ICD-10 and has instructed its MACs to reconfigure test environments specifically for ICD-10 to help support provider readiness. Two types of testing are available: acknowledgement testing that allows providers to test their ability to submit ICD-10 codes, and end-to-end testing that simulates full claims adjudication.

ICD-10 acknowledgement testing is available at any time to all electronic submitters through September 30, 2015. In addition, CMS has conducted four acknowledgement testing weeks in March 2014, November 2014, March 2015 and June 2015 to provide for additional submitter customer service and help desk support to help providers work through identified issues.

CMS is also conducting end-to-end testing with providers. The first two testing periods occurred in January and April 2015; the final end-to-end testing period occurs July 20-24. End-to-end testing differs from acknowledgement testing in that it involves the full claims adjudication cycle, and as such requires extensive time and resources up-front to prepare our systems and load appropriate claims history and demographics for the providers and beneficiaries used in testing. Testers are permitted to submit up to five National Provider Identifiers (NPIs) each and up to 50 claims. Between January and April, approximately 3,000 NPIs were registered to participate in end-to-end testing representing a broad-range of provider and claim types.

Overall, CMS believes this two-tiered external testing approach, in addition to extensive CMS internal testing, has been sufficient to broadly evaluate the ability of Medicare FFS systems to accommodate ICD-10 and appropriately adjudicate ICD-10 coded claims.

Additionally, you proposed that CMS promote awareness of resources such as Internet-based portals to submit claims with ICD-10 codes; and established regulatory processes that allow advanced or accelerated payments under certain circumstances. CMS has created tailored training, resources, and tools specifically to help physicians and their staffs prepare for the ICD-10 transition. CMS has developed multiple tools and resources that are available on the ICD-10 website (<http://www.cms.gov/ICD10>), including ICD-10 implementation guides, tools for small and rural providers, and general equivalency mappings (ICD-9 to ICD-10 crosswalk). We also have expanded our free training for providers across the country through national provider calls and webinars, training videos, and testing; and created tools and resources like the CMS website and Road to 10 Tool.

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

CMS will be releasing additional educational products and revising existing products found at <http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html>. Included will be information about the claims submission alternatives available for providers who are unable to submit ICD-10 diagnosis codes due to problems with their billing systems.

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

Lastly, you advised CMS to coordinate with non-Medicare payers on the above activities to the extent feasible. Our ICD-10 work at CMS is part of the larger health care community's efforts to implement ICD-10. CMS continues to collaborate and partner with all industry stakeholders. The Agency hosts national weekly implementation meetings with provider groups, industry stakeholders, clearinghouses, vendors, and commercial payers. We have called for the healthcare industry at-large to align its outreach efforts to provide the necessary resources and guidance to help physicians make the transition to ICD-10.

There is a critical need to move from the over 35-year-old ICD-9 coding system to ICD-10. Dramatic advances in medicine have occurred, and ICD-9 codes are not specific enough to adequately capture diagnoses and services furnished. ICD-10 provides greater specificity to diagnosis-related groups and improves quality measurement and reporting capabilities needed for the Merit-based Incentive Payment System and the Alternative Payment Models as provided in the Medicare Access and CHIP Reauthorization Act of 2015. ICD-10's granularity will improve data capture and analytics of public health surveillance and reporting, national quality reporting, and research and data analysis. ICD-10 provides detailed data to inform health care delivery and health policy decisions.

The health care industry has invested significant resources toward the implementation of ICD-10. Many providers, including physicians, hospitals, and health plans, have already completed the necessary system changes to transition to ICD-10. Additional delays would pose significant costs for providers who have updated their systems. The 2014 final rule titled "Administrative Simplification: Change to the Compliance Date for the International Classification of Diseases, 10th Revision (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets" and published on August 4, 2014 (79 FR 45128) estimated the costs of the recent one year ICD-10 delay at \$422 million to \$3.8 billion for hospitals and large providers and between \$547 million and \$2.7 billion for commercial health plans and third party administrators. Maintaining the current implementation date would spare these providers from incurring further costs.

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Thank you for your interest in this important topic. We look forward to working with Congress as we transition to ICD-10 on October 1, 2015. I will provide a copy of this response to the co-signers of your letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Andrew M. Slavitt". The signature is fluid and cursive, with a horizontal line at the end.

Andrew M. Slavitt
Acting Administrator