



MGMA
Government
Affairs

NCVHS Subcommittee on Standards

ICD-10 Planning, Testing, Implementation

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About MGMA



- MGMA is the premier association for professional administrators and leaders of medical group practices
- Since 1926, the association has delivered networking, professional education and resources, political advocacy and certification for medical practice professionals
- MGMA has
 - 22,500 members...
 - Who manage and lead 13,600 organizations
 - Where 280,000 physicians provide more than 40% of U.S. physician services

Key Consideration – Trading Partner Coordination



For physician practices, successful ICD-10 implementation requires a number of essential steps:

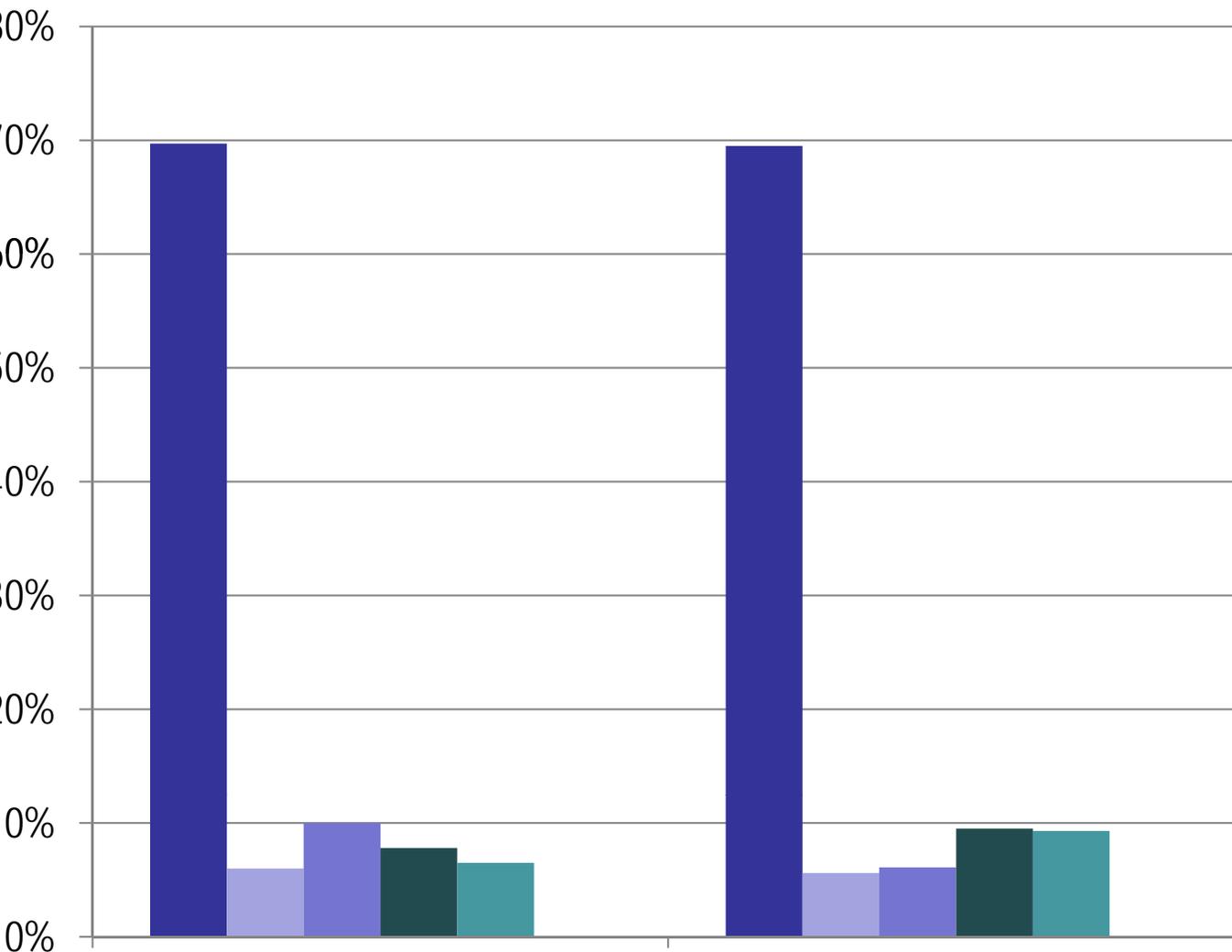
1. Internal impact assessment
2. Documentation review/modification
3. Clinical / administrative staff training
4. PM/EHR software change
5. Internal testing
6. External testing with clearinghouse
7. External testing with major health plans for:
 - a) Technical (will the claim get through the front door)
 - b) Payment policies (will the claim be paid)

MGMA Research



- Conducted June 5-11
- 1,195 respondents from medical groups where more than 55,000 physicians practice
- Groups ranged in size from 1 to 700, with 73.6% being 20 or smaller
- 44 medical specialties represented

PM/EHR software need an upgrade or replacement?



- Will/did need an upgrade
- Will/did need to be replaced
- Will need to be replaced or upgraded, but we are unsure at this time which will be required
- No, will not/did not need to be replaced or upgraded
- Do not know

Cost to upgrade or replace PM/EHR for a 10 FTE Practice = \$201,690



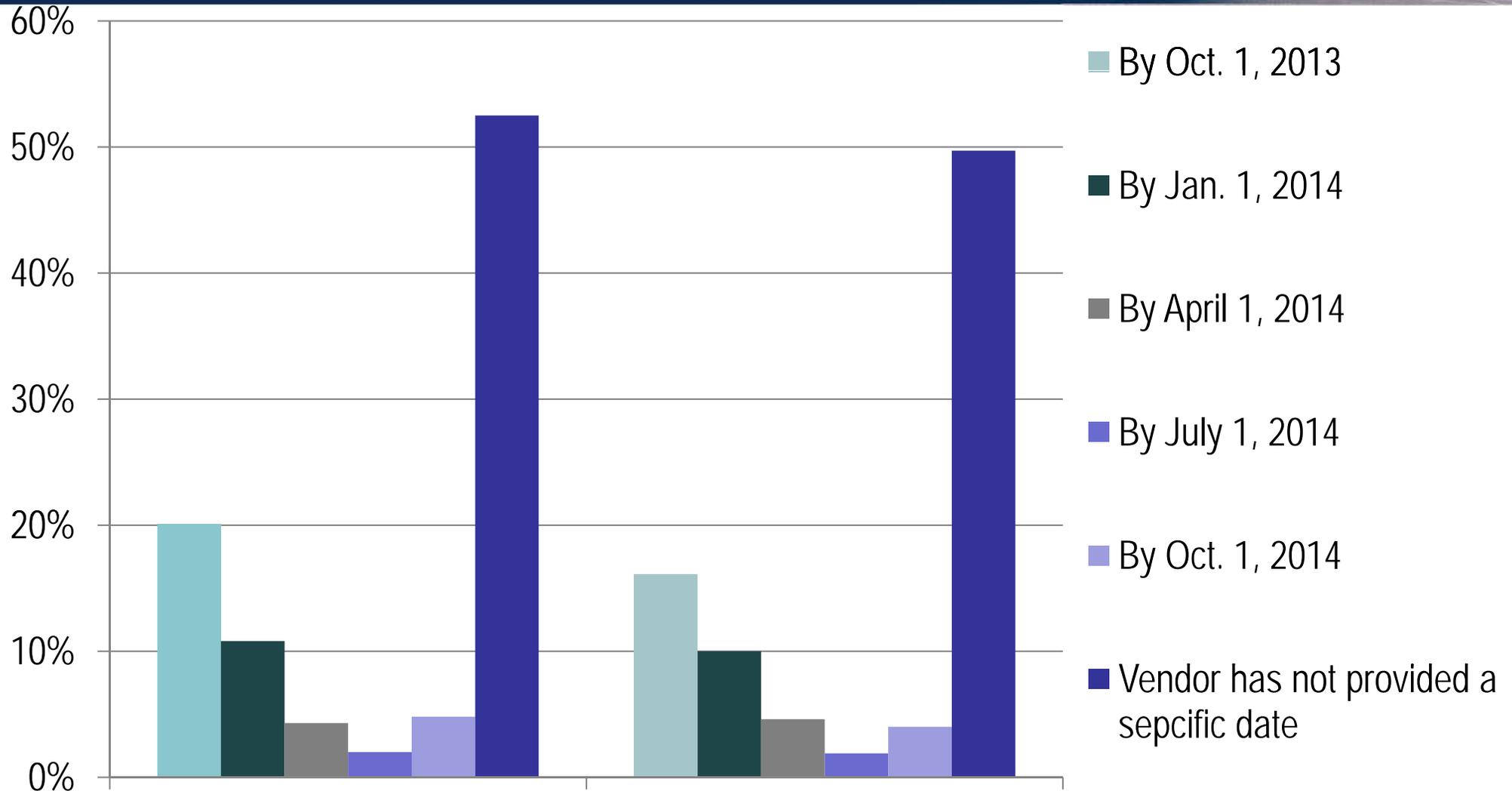
Approximately how much will it cost, or did it cost, to upgrade or replace your Practice Management System?

Average cost per FTE physician:	\$10,190
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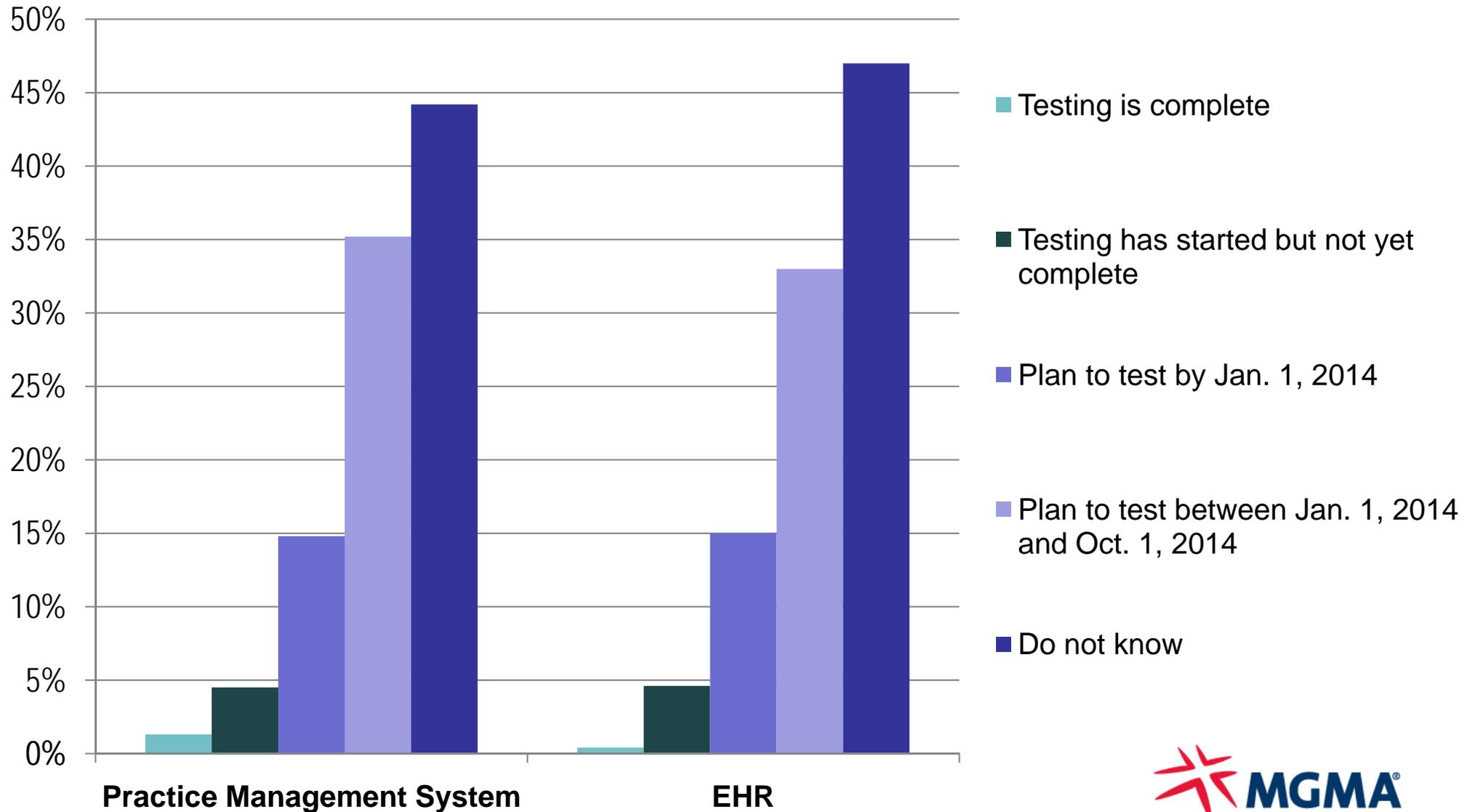
Approximately how much will it cost, or did it cost, to upgrade or replace your EHR?

Average cost per FTE physician:	\$9,979
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When has your vendor indicated that they will make the upgrade or replacement available?



Scheduled date to begin ICD-10 testing with PM/EHR



ICD-10 testing with health plans and clearinghouse



When have the following entities indicated that they will be ready to accept test claims?

Answer Options	Fully tested	Started to test but not yet completed	Plan to test by Jan. 1, 2014	Plan to test between Jan. 1, 2014 and Oct. 1, 2014	We have not heard from entity
Your major health plans	0.5%	8.2%	6.5%	13.6%	71.2%
Your clearinghouse	2.3%	9.4%	12%	16.3%	60%

Level of concern with the following ICD-10 implementation issues:



Answer Options	Not at all concerned	Of little concern	Moderately concerned	Concerned	Very concerned
Overall cost of converting to ICD-10	1%	4.2%	13.4%	25.5%	55.6%
Cost of upgrading or replacing practice software	5%	11.1%	14.4%	26.2%	42.8%
Changes to clinical documentation	0.7%	1.8%	8.5%	19.2%	69.8%
Loss of clinician productivity after implementation	0.7%	3.5%	8.3%	17.4%	70.1%
Loss of productivity of coding staff after implementation	1%	3.7%	8.1%	19.5%	67.3%
Ability to obtain executive management support for the	12.3%	19.8%	18.4%	21.6%	27.9%

Expected change in difficulty to accomplish the following activities:



Answer Options	Much less difficult	Somewhat less difficult	No change	Somewhat more difficult	Much more difficult	Not applicable
Ability to document the patient encounter	0.4%	0.7%	9.3%	37.6%	51.5%	0.5%
Ability of clinician to select appropriate diagnosis code	0.4%	0.9%	2.3%	20.9%	74.9%	0.6%
Ability of coding staff to select appropriate diagnosis code	0.3%	1.5%	3.6%	33%	59.3%	2.3%
Ability to include most frequently used diagnosis codes on a superbill	0.6%	0.7%	8.6%	22.3%	57.1%	10.7%
Ability to compare new diagnosis data in ICD-10 with previously collected data using ICD-9	0.4%	1.6%	5.2%	36.4%	55.3%	1.1%
Ability to outsource billing	1.4%	1.5%	25.4%	10.2%	13.2%	48.3%

Claims Processed by Clearinghouse



Approximately what percentage of your health insurance claims are processed by a clearinghouse?

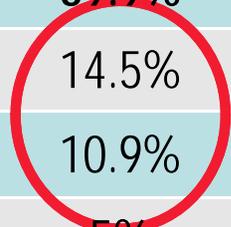
Answer Options	Response
None	2.8%
Less than 20 percent	1.7%
20 percent to 39 percent	1.5%
40 percent to 59 percent	3.8%
60 percent to 79 percent	7.2%
80 percent to 99 percent	51.5%
100 percent	27.2%
Do not know	4%
Not applicable	0.3%

Use of Unspecified Diagnosis Code



In your current billing environment, approximately how often do you select “unspecified” as the ICD-9 diagnosis code?

Answer Options	Response
Never	8.7%
10 percent of the time or less	39.9%
11 percent to 20 percent of the time	14.5%
21 percent to 30 percent of the time	10.9%
31 percent to 40 percent of the time	5%
41 percent to 50 percent of the time	3%
More than 50 percent of the time	3%
Do not know	14%
Not applicable	1%



Palmetto Statement on ICD-10 Testing



- Medicare does not plan to pursue testing of Medicare fee-for-service (FFS) claims directly with providers for ICD-10 at this time. The Centers for Medicare & Medicaid Services (CMS) feels confident that the current level of testing that is done each quarter for any changes to the Medicare claims processing systems is effective to ensure that claims will be processed properly and that ICD-10 diagnosis codes will be accepted and claims will be processed correctly.
- Implications:
 - Provides cover for commercial plans not to test
 - Adds tremendous uncertainty to the Oct. 1, 2014 switch
 - Suggests abdication of responsibility

Conclusions



- Key inter-trading partner actions (upgrades, testing) not occurring at the pace required
- Physician practices must rely on software upgrades and many have not heard from their vendors about testing
- Practices facing significant software upgrade/replacement costs
- Considerable concern regarding code selection, clinical documentation, loss of productivity, cost of transition
- Vast majority of practices use clearinghouses, unspecified codes
- Clearinghouses cannot solve all ICD-10 problems

Recommendations to HHS



- Reverse policy not to test with external trading partners
- Release Medicare/Medicaid ICD-10 related payment policies
- Fully engage with the HIMSS-WEDI National Testing Pilot
- Identify and publicize productivity impact
- Ramp up education and resources to all stakeholders (special emphasis on vendors, small, rural and safety net providers)
- Focus on the role of the clearinghouse
- Leverage the RECs to help reach smaller practices (expand their mandate to include medical specialties other than primary care)
- Harmonize federal initiatives (quality reporting, operating rules and other ACA-mandated admin simp requirements, meaningful use)
- Support a PM certification process