KEY-WHITMAN EYE CENTER

Dallas, TX

RE: ICD-10 Issues

To: Chairman Pete Sessions
House Committee on Rules
2233 Rayburn House Office Building
Washington, D.C. 20515-4332

Recently, an inquiry by you was made regarding our position on the implementation of ICD-10. Based upon our vast experience in medicine, coding, reimbursement, clinical productivity and integrated information systems, we offer the following key points.

1) First and foremost, tying CMS reimbursement with detailed clinical coding information with the required granularity of ICD-10 is fraught with a host of impractical implementation issues. While better clinical coding systems are desirable for clinicians and statisticians monitoring public health trends, ICD-11 planned for 2017 may do a much better job, and ICD-10 is not a transitional system. Reimbursement detail, for the most part, is irrelevant to clinical coding when correlating it with the full scope of ICD-10 digits being mandated in the USA. Accuracy is predicted to be very poor since the emphasis will be on reimbursement rather than clinical value. Practically all the other nations of the world do not tie ICD-10 with reimbursement, and other nations in the use of ICD-10 vary considerably amongst advanced nations. It has been stated that no other nation will use ICD-10 like the United States intends to use it. So, adopting the ICD-10 system because many other nations use it really does not hold much value or analytical comparability.
2) Given our recent industry history of implementing the E.H.R. or E.M.R. systems for medical practices, many of our I.T. systems are simply incapable and cratering under the pressure of meeting Meaningful Use 2 goals, besides the PQRS reporting requirements, placing the complexity of the ICD-10 program on top of the MU-2 stages & PQRS mandates is going to overwhelm most practices given their level of employed personnel and I.T. support services. The staggering implementation of multiple complex systems simultaneously with lower level educated personnel will simply not work well in reaching the goals. Failure, similar to the start-

up of "healthcare.gov," will be repeated. Delaying the implementation will be helpful when the other informational programs are more stable.

3) The relative impact on productivity and workflow will be costly for the medical practice, adding personnel to handle the detailed processes of ICD-10 for reimbursement, as well as prolonging the processing of patients, will slow the current system by 5-10%, in my opinion. More effort will be directed to documenting the ICD-10 process than attending to the clinical needs of the patient.
4) The cost of training and preparation will be extremely costly for most practices, amounting to many thousands of dollars per doctor for each practice on top of the declining reimbursement trends and escalation of more elaborate cost to support the new electronic health systems. I predict that the cost squeeze will bankrupt smaller practices unprepared to handle the cash flow needs of the ICD-10 implementation in 2015. Delaying it to 2018 would be a better solution, as we will likely implement ICD-11 at that time.
5) Many practice management systems that do the billing for medical practices will likely not be fully capable, despite the lead time provided with the extension. As I sit on the Board of an I.T. company that hosts a variety of billing systems, we are fully aware of their inadequacies since we test their performance levels. The testing process is not adequate with so much at stake financially for medical practices.
6) Expectations of the payers to be prepared for the full implementation of ICD-10 will not occur. They have had trouble with the 5010 implementation. They have a lot of trouble with the Quality/Cost database ratings of physicians. As we have continually experienced, system upgrades by United Health Care, Cigna, Aetna, Blue Cross, Wellpoint, etc. , they rarely are prepared for such major changes on a timely basis. Major overhauls of their I.T. claim processing systems have historically been poor at best. Thus, reimbursement claims will be denied, unpaid, improperly paid, and re-worked at a staggering level. Payers have little incentives to be fully prepared on time, and much to gain by holding back payments. Medical practices will predictably need additional months of working capital funds just to get through the implementation, and our tax system does not encourage a build-up of working capital by physicians to survive the ICD-10 implementation.

In conclusion, we see no need to upgrade to the ICD-10 by October 1, 2015 which will be extremely costly to medical practices without any value, and we would see our national system better served adopting ICD-11 by 2018 with more testing and stabilization of our current EMR / EHR installations along with PQRS compliance.

Respectfully,

Daniel D. Chambers
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