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EXAMINING ICD-10 IMPLEMENTATION

WEDNESDAY, FEBRUARY 11, 2015

House of Representatives,

Subcommittee on Health

Committee on Energy and Commerce

Washington, D.C.

The Subcommittee met, pursuant to call, at 10:15 a.m., in Room 2322 of the Rayburn House Office Building, Hon. Joe Pitts [Chairman of the Subcommittee] presiding.

Members present: Representatives Pitts, Guthrie, Barton, Whitfield, Shimkus, Burgess, McMorris Rodgers, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Green, Butterfield, Castor, Sarbanes, Schrader, Kennedy,

Cardenas, and Pallone (ex officio).

Staff present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Leighton Brown, Press Assistant; Jerry Couri, Senior Environmental Policy Advisor; Andy Duberstein, Deputy Press Secretary; Robert Horne, Professional Staff Member, Health; Chris Sarley, Policy Coordinator, Environment and Economy; Adrianna Simonelli, Legislative Clerk; Heidi Stirrup, Health Policy Coordinator; Traci Vitek, Detailee; Ziky Ababiya, Democratic Policy Analyst; Jeff Carroll, Democratic Staff Director; Tiffany Guarascio, Democratic Staff Director and Chief Health Advisor; Ashley Jones, Democratic Director, Outreach and Member Services; and Arielle Woronoff, Democratic Health Counsel.

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Mr. {Pitts.} The subcommittee will come to order. The chair will recognize himself for an opening statement.

The United States currently operates under the International Classification of Diseases, 9th Revision (ICD-9) code set, which has about 13,000 diagnostic codes. The Department of Health and Human Services (HHS) had set a mandatory deadline of October 1, 2013, for providers to switch from ICD-9 to the greatly expanded ICD, 10th Revision (ICD-10) code set, which has 68,000 diagnostic codes and 87,000 procedural codes.

Section 212 of H.R. 4302, the Protecting Access to Medicare Act, signed into law by President Barack Obama on April 1, 2014, delayed the transition to ICD-10 until October 1, 2015. Many providers and payers, including the Centers for Medicare and Medicaid Services, have already made considerable investments in the ICD-10 transition, and any further delay will entail additional costs to keep ICD-9 systems current, to retrain employees, and to prepare, again, for the transition.

The United States currently lags behind most of the rest

of the world, which already uses the updated ICD-10. ICD-9 is more than 30 years old and does not capture the data needed to track changes in modern medical practice and healthcare delivery.

I would like to welcome all of our witnesses today. We look forward to your testimony on this important subject.

[The prepared statement of Mr. Pitts follows:]

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Mr. {Pitts.} With that, I will yield back and recognize the ranking member of the subcommittee, Mr. Green, for 5 minutes.

Mr. {Green.} Thank you, Mr. Chairman, and good morning and thank you to all our witnesses for being here today.

As we know, ICD-9 was adopted in the United States nearly 40 years ago. Congress included a requirement that providers transition to ICD-10 in the Health Insurance Portability Act of 1996. Since then, transition has been delayed twice to give covered entities time to prepare. ICD-10 transition is currently set to take place on October 1, 2015. It is time to move forward without further delay.

ICD-9 was developed in 1979 and there has been significant medical breakthroughs which ICD-9 doesn't have codes. ICD-10 will include the more accurate medical descriptions and account for varying symptoms and levels of security. More precise and appropriate codes have a number of benefits to our health care system. Precise information will improve claims processing. Insurers will reject fewer claims and not have to ask to provide more information as

often as they currently do. The improved specificity of ICD-10 will help researchers. It will allow public health officials to better track disease and outbreaks.

The Affordable Care Act included provisions to move our health care system from one that rewards value instead of just volume. There is still a lot of work to do to improve our system in this regard, and adopting ICD-10 without delay would help move this forward.

Providers are increasingly evaluated and held accountable based on patient outcomes so more accurate codes can help providers improve their patient safety efforts.

RAND estimated that the cost of transitioning would be between $475 million and $1.5 billion over 10 years but that the benefits of the system would be between $700 million and $7.7 billion in cost savings. According to their analysis, this is due to more accurate payments, improved disease management, less rejected claims and fewer fraudulent claims. The transition to ICD-10 is supported by a majority of the health care community, a broad-based coalition including hospitals, health plans, medical device manufacturers, and the health information community opposes any further delay.

Each has invested substantial time and resources, and further delay will be costly and wasteful.

I understand the medical community has had mixed reactions to the transition. Many have invested time and resources to be ready for October 1st yet some tell us they are not ready. The Centers for Medicare and Medicaid Services says it is ready for the transition. CMS has a technical assistance website that features resources to help providers and others with the transition to ICD-10. It has engaged in targeted outreach to facilitate the switch. Between CMS and the Coalition for ICD-10, the resources available to help the transition are significant. Many of these are available online for free.

Each delay has been costly to the health care system, and ICD transition is an important part of bringing our health care system into the 21st century, and I yield back my time. Wait a second. Does anyone want my time on our side? I yield back my time, Mr. Chairman.

[The prepared statement of Mr. Green follows:]

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Mr. {Pitts.} The chair thanks the gentleman, and now recognizes Dr. Burgess 5 minutes for an opening statement.

Mr. {Burgess.} Thank you, Mr. Chairman. I appreciate the recognition. I appreciate our witnesses being here and spending time with us this morning at this hearing. I am certainly glad we are having the hearing. It is something that I have been asking for for some time. I am very glad we are here today talking about our readiness and preparedness and have not delayed that until September.

While the transition has been delayed several times by various mechanisms, the last-minute delays do nothing to relieve the pressure for the small practice that struggles under this administrative burden. It does put the health systems and the insurers in a difficult position as well. In fact, it punishes those who have done exactly what Congress has requested.

So we do need to hear from our witnesses. Are we doing this or not? If we are, then the big question for you and me becomes, will we be ready?

Now, I understand that most of the claims processing

will be done by Medicare contractors and insurance companies. I actually have a great deal of faith in their ability to move data. That is what they do. But all roads eventually lead to the Centers for Medicare and Medicaid Services, and if you will pardon me, that does appear to be a weak link in the chain, because from healthcare.gov to the Sunshine Act reporting website, when CMS flips a switch, something breaks, and it is invariable, and it has happened time and again. Any time they flip a switch and it involves the processing of data, their systems fail.

So it begs the question, is flipping a switch on October 1st the right move? If it is, then what is the contingency plan for any problems that may develop? Now, contingency plan is a phrase I use advisedly because it has been in this subcommittee and in the Oversight Subcommittee time and again. With the lead-up to healthcare.gov, I asked Gary Cohen, I asked Secretary Sebelius, what are the contingency plans if all does not go well when you turn this thing on, and I was told no contingency plan necessary, we will be ready October 1st. That was October 1st, 2013. We know what happened after that.

So forgive me if I keep repeating the point that I have asked for contingency plans in the past, I have been told they are not necessary, that everything is fine, until it isn't, and then we all scramble. In this case, it could mean disruptions in patient care and the ability of small practices to actually meet their fiscal obligations that they are required to meet to stay in business.

So today I am anxious to discuss not just the plan ahead for the implementation but I would also like to talk about the contingencies if everything doesn't go exactly as planned.

Thank you, Mr. Chairman, for the recognition. I will yield back the time.

[The prepared statement of Mr. Burgess follows:]

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Mr. {Pitts.} The chair thanks the gentleman. That concludes the opening statements. As usual, all members' written opening statements will be made a part of the record.

I would like to ask unanimous consent to submit seven documents for the record: a statement on ICD-10 from the American Hospital Association; a letter of support from the ICD-10 Coalition; a statement from the Premier Healthcare Alliance on ICD-10; comments from the American Medical Association; comments from the American Academy of Dermatology Association; statement from the American Academy of Orthopedic Surgeons; and a statement from Precyse, a leader in performance management and technology focused on health information management. Without objection, so ordered.

[The information follows:]

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Mr. {Pitts.} We have one panel before us today. I will introduce them at this time in the order that they speak: Dr. Edward Burke from the Beyer Medical Group; Mr. Rich Averill, Director of Public Policy at 3M Health Information Systems; Ms. Sue Bowman, Senior Director for Coding Policy and Compliance at American Health Information Management Association; Ms. Kristi Matus, Chief Financial and Administrative Officer at Athena Health; Ms. Carmella Bocchino, Executive Vice President, Clinical Affairs and Strategic Planning at America's Health Insurance Plans; Dr. William Jefferson Terry, a Member of the American Urological Association, a Physician at Urology and Oncology Specialists; and Dr. John Hughes, Professor of Medicine at Yale University.

Thank you all for coming. Your written statements will be made a part of the record. You will each be given 5 minutes to summarize your testimony, and we will start with you, Dr. Burke. You are recognized 5 minutes for your summary.

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^STATEMENTS OF DR. EDWARD BURKE, BEYER MEDICAL GROUP; RICHARD AVERILL, DIRECTOR OF PUBLIC POLICY AT 3M HEALTH INFORMATION SYSTEMS; SUE BOWMAN, SENIOR DIRECTOR FOR CODING POLICY AND COMPLIANCE AT AMERICAN HEALTH INFORMATION MANAGEMENT ASSOCIATION; KRISTI MATUS, CHIEF FINANCIAL AND ADMINISTRATIVE OFFICER, ATHENA HEALTH; CARMELLA BOCCHINO, EXECUTIVE VICE PRESIDENT, CLINICAL AFFAIRS AND STRATEGIC PLANNING AT AMERICA'S HEALTH INSURANCE PLANS; DR. WILLIAM JEFFERSON TERRY, MEMBER OF THE AMERICAN UROLOGICAL ASSOCIATION, A PHYSICIAN AT UROLOGY AND ONCOLOGY SPECIALISTS; AND DR. JOHN HUGHES, PROFESSOR OF MEDICINE, YALE UNIVERSITY

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^STATEMENT OF EDWARD BURKE

} Mr. {Burke.} Good morning, and thank you for the opportunity to share our journey into ICD-10. My name is Dr. Edward Burke. I practice internal medicine in a small, rural community in Missouri with a population of about 4,000 people. I work with a family practice physician, three nurse practitioners, and a mental health provider. We see patients

of all ages.

Providers face unique challenges while serving in rural areas due to accessibility and lack of resources. The challenges to running a successful business in healthcare can be just as difficult for the same reasons. The information highway often overlooks the side roads. In an industry full of rules and regulations, it is imperative to keep abreast of anything new coming down the pipe. Being out of the loop often means being left behind.

ICD-10 has been on the horizon for several years now. We were ready for it, and our software vendor was ready for it. When the date was postponed, we moved forward. We believed the implementation of ICD-10 would eventually happen and that we would be even more prepared. With all the changes coming in healthcare, this was one we would tackle in full confidence. What we were unprepared for was how seamless it was. On a busy Monday morning, October 7, 2013, we took on ICD-10 and we haven't looked back. We did not have special training. We did not spend any money in preparation. We did not see less patients and our practice did not suffer. As providers, it was not frustrating or

scary. It just was.

Why did this work so well for us? A combination of things in our opinion, most of all teamwork and leadership. We have providers who work well with each other and with the rest of the staff. We are a close-knit medical office family, understanding that we are only as strong as our weakest employee.

It is important to have a leader on the staff that is progressive and knowledgeable about what is coming, someone who comes prepared with a plan of action. No office should be without a professional practice manager, one who has certification to back up what years of experience has given. The relationship between professional practice managers and physicians is critical and often means the difference in success and failure.

Associations such as PAHCOM offer practice managers the knowledge needed to navigate through the many changes in rules and regulations. Our industry is riddled with what you can do and what you cannot do. PAHCOM provides access to information critical to running a successful medical office.

The other prominent factor was our software. We chose

to implement highly effective software when we made the decision to transition to electronic medical records. Our practice manager looked at some of the things coming in the near future and chose software that would grow and expand to what we would need and that would be ready when we needed it. The road to ICD-10 was driven by our EHR vendor. They extended an offer to us to be a part of a pilot program for implementing ICD-10. We were very happy to be a part of it. Our thinking was, it gives us time to play with it and learn it before it really counts. We had no idea how easy it was going to be. We just wanted to take advantage of every possible source of information before each stroke counted financially. We did not feel we could be too prepared. We were as apprehensive as everyone else. Communication is the most important tool in eliminating errors, providing quality care and improving outcomes. There are several pieces that must come together, with the same information, in order to complete one simple procedure.

Speaking the same language is crucial to patient care. ICD-10 is that language. As all processes change and improve over time, so should our diagnosing. ICD-10 provides clear,

concise descriptions of the problem a patient is having. The specifications narrow margins of error since the picture is clearer. The drill-down structure of the system provides an accurate description of the problem.

As the world becomes ever smaller it is important to see healthcare with a broader view. Even in our small community, it is not uncommon for patients to be traveling outside of the country. It is important to understand that we are affected by the health of locations outside our homes. To speak the same healthcare language is imperative. As a Nation, we are behind. As an industry, we are behind. As healthcare providers, we can do better. We must be open to change and to the possibility that a different way can work. ICD-10 is truly better than what we currently have. The benefits to ICD-10 have been well touted as well as the drawbacks. We do not claim to have to have the answers or formula that will work for every provider situation but it worked for us.

We used ICD-9 on a Friday and ICD-10 on the following Monday. We are very pleased with our decision to keep using ICD-10 and encourage others to support this move. Accuracy

and positive outcomes are of course important goals in patient care. Fine-tuning diagnoses help paint a clearer picture of what is happening with a patient.

The important thing to understand is that ICD-10 helps, not hinders, patient care. There are many issues that are debatable in healthcare today. Anything that so clearly helps the patient should not be one of them. ICD-10 should move forward. Healthcare moves fast. You cannot blink. Putting off ICD-10 is not blinking; it is closing your eyes.

We do not wish to discredit rational objections to transitions to ICD-10. Each situation will present its own pains and struggles. We just wish to share our story and maybe ease some lingering fear. It wasn't hard, it wasn't expensive and it wasn't time consuming. Clinical documentation did not change. We spend the same amount of time documenting to support ICD-10 as we did with ICD-9. We did nothing different. We use it every day. It is a normal part of our encounter with a patient. The most important issue was that it was not disruptive to patients.

We strongly support full implementation of ICD-10. We believe ICD-10 is a better communication tool and we believe

it will truly be a benefit in the care of patients.

Thank you again for the opportunity to share our experiences.

[The prepared statement of Dr. Burke follows:]

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Mr. {Pitts.} Thank you, Dr. Burke.

The chair now recognizes Mr. Averill 5 minutes for an opening statement.

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^STATEMENT OF RICHARD AVERILL

} Mr. {Averill.} 3M appreciates the opportunity to testify this morning.

ICD-10: We need it. We are ready. This is the message I want to make sure that I convey to the committee today.

The current system used for reporting diagnosis and procedures, ICD-9, was developed nearly 40 years ago. When ICD-9 was developed, you could smoke in a patient's room. There was no personal computer. There was no Internet. Minimally invasive procedures were not even envisioned.

ICD-9 reflects medicine of a bygone era. With ICD-9, we often don't know what is really wrong with the patient or what procedures were performed. ICD-9 codes like a repair of an unspecified artery by an unspecified technique are virtually useless for establishing fair payment levels and evaluating outcomes.

I was one of the original developers of the DRGs at Yale University. Since the inception of the Medicaid Inpatient Prospective Payment System by President Reagan and Speaker

O'Neill, I have worked with CMS to maintain and update the DRGs. The biggest frustration with DRG updates is that proposed DRG modifications from the health care industry often cannot even be evaluated because there are no ICD-9 codes available.

Congress rightly wants to move to a health care system that focuses more on value than volume. I am here to tell you, you can't do that with ICD-9. You need ICD-10. It is time to have our diagnosis and procedure coding system reflect modern medicine.

The RAND report commissioned by the National Committee on Vital and Health statistics concluded that the ICD-10 benefits from more accurate payments, fewer rejected claims, fewer fraudulent claims, better understanding of new procedures, and improved disease management would far exceed the cost of implementation. It is time to start realizing those benefits.

The industry is ready. The transition to ICD-10 is supported by the vast majority of the health care community--hospitals, health plans, coding experts, physician office managers, vendors, medical device manufacturers, health

informatics specialists, and some in the physician community. All support the adoption of ICD-10 in October of 2015.

Unfortunately, the uncertainty over the ICD-10 implementation date means the whole industry has to maintain fully functional systems in both ICD-9 and ICD-10. Maintaining redundant ICD-9 and ICD-10 systems is very costly. Any further delay means more wasted cost. Last year's delay is estimated to have cost the health care industry $6.5 billion.

Perhaps the biggest challenge to a smooth transition to ICD-10 is the uncertainty of the implementation date. It is simply time to end that uncertainty and allow the whole health care industry to move forward with a smooth transition.

Questions have been raised concerning the ability of CMS to move forward with ICD-10. For CMS and its fiscal intermediaries, the implementation of ICD-10 is primary an update to its claims processing system. While admittedly CMS has encountered some difficulties with newly constructed consumer-facing websites, CMS has extensively experience implementing significant updates to its claims processing

system. As the recent GAO report demonstrates, CMS has done extensive ICD-10 planning, preparation, testing and outreach. For example, in order to facilitate vendor and hospital ICD-10 preparation, CMS made available a fully operational version of the ICD-10 MSDRG software more than a year ago. Providers, clearinghouse, payers including CMS are all testing and will continue to test. Testing results show that the system is ready for those who have taken the time to prepare.

As I said in the beginning, ICD-10, we need it, we are ready. As a member of the Coalition for ICD-10, we strongly oppose any further delay to the adoption of ICD-10. The Coalition stands ready to help in any way to ensure a successful transition to ICD-10 in October of 2015. Thank you.

[The prepared statement of Mr. Averill follows:]

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Mr. {Pitts.} The chair thanks the gentleman and now recognizes Ms. Bowman 5 minutes for her summary.

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^STATEMENT OF SUE BOWMAN

} Ms. {Bowman.} Good morning. On behalf of the American Health Information Management Association, or AHIMA, I would like to thank you for the opportunity to testify today on the very important topic of ICD-10 implementation.

Implementation of ICD-10 is long overdue. Never before in U.S. history has the same version of ICD been used for more than 30 years. ICD-9 is obsolete and no longer reflects current clinical knowledge, contemporary medical terminology or the modern practice of medicine.

U.S. health care data is being allowed to deteriorate while the demand continues to increase for high-quality data, data that can support health care initiatives such as the meaningful use of electronic health record Incentive Program, new payment models, and other initiatives aimed at improving quality and patient safety and decreasing costs. ICD-10 also improves tracking and surveillance of pandemic threats such as Ebola, which does not have its own ICD-9 code.

The number of ICD-10 codes has been raised as a concern.

The expanded clinical detail in ICD-10 was requested by the medical community because these clinical distinctions were felt to be important to capture. A number of physician organizations continues to actively participate in the ongoing maintenance of ICD-10 by requesting additional clinical detail. Ninety-five percent of the requests for new ICD-10 comes have come from the medical community, especially the physician organizations.

Just as the size of a dictionary or phone book does not make it more difficult to look up a word or a phone number, an increased number of codes does not make it harder to find the right code. Increased specificity, clinical accuracy, and a logical structure actually facilitate rather than complicate the use of a code set. Also, no individual provider will use all of the ICD-10 codes but rather he will use a subset of codes applicable to his clinical practice and patient population. And nearly half of the increase in codes is due solely to the capture of the side of the body affected by the clinical condition.

The specificity of the external cause codes has also been raised as a concern. External cause codes, or the

reason why an injury occurred, are not unique to ICD-10. They exist in ICD-9 as well. Many providers are not currently required to report external cause codes unless a provider is subject to a State-based external cause code reporting mandate or these codes are required for a particular patient circumstance. Reporting of external cause codes in either ICD-10 or ICD-9 is not required. And even when external cause codes are required, many of them are for use in very specific circumstances. Most providers have probably had no occasion to assign the existing ICD-9 code for an accident involving injury to the occupant of a spacecraft but the fact that such a code exists has not made ICD-9 more difficult to use.

Many small providers have been concerned about anticipated high cost and complexity of the ICD-10 transition. However, recent data such as the results of a survey of small physician offices conducted by the Professional Association of Health Care Office Management, or PAHCOM, that were just released yesterday, have shown the cost and burden to be much less than earlier predictions. And physician practices do not need to implement the ICD-10

procedure code or ICD-10 PCS as CPT codes will continue to be used to report physician and outpatient services.

Training is one of the factors in the cost of implementation but the extent of ICD-10 training needed depends on the individual's role. Physicians will primarily require education around the clinical documentation needed to support ICD-10 codes. Additional documentation requirements have often been cited as a major contributor to the cost of ICD-10 implementation. However, even without the ICD-10 transition, there is a growing demand for more a complete and accurate documentation, and the impact of clinical documentation improvement efforts can be mitigated through the use of electronic documentation capture tools such as documentation prompts in electronic health record systems. Also, many of the clinical details found in ICD-10 are typically already documented such as laterality.

Free and low-cost ICD-10 educational implementation resources are widely available from multiple sources, giving all stakeholders the ability to be fully ready by the compliance date. Each delay in ICD-10 implementation has taken an enormous toll on the health care industry including

significant additional costs, diversion of ICD-10 budgets and personnel, lack of employment prospects for students trained in a code set not yet in use, and many lost opportunities to use better data to improve health care and reduce costs.

The health care industry has had more than 6 years to prepare. It is time to stop delaying the transition to ICD-10. We need ICD-10, and we are ready.

Thank you for the opportunity to testify.

[The prepared statement of Ms. Bowman follows:]

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Mr. {Pitts.} Thank you, Ms. Bowman.

At this point the chair recognizes Ms. Matus 5 minutes for her summary.

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^STATEMENT OF KRISTI MATUS

} Ms. {Matus.} Chairman Pitts, Ranking Member Green, members of the subcommittee, thank you for this opportunity to share our perspective on the important issue of ICD-10 implementation and its implications for our broader, bipartisan health reform efforts.

My name is Kristi Matus, and I am the Chief Financial and Administrative Officer for athenahealth, a provider of cloud-based health information technology services to more than 60,000 care providers nationwide in all 50 States, connecting care for over 60 million patients.

Every one of our clients is on a single national Internet-based network that we use to connect with them in real time on a daily basis like Amazon, Facebook or Google. As you may know, this is a paradigm that is all too rare in health care.

Based on our experience with partnering with medical practices to improve efficiency and outcomes, our point of view is simple: it is decision time. Maintain the current

date for ICD-10 implementation or cancel it once and for all. Do not allow another delay.

Our Nation has an extraordinarily ambitious, largely bipartisan health care agenda. From the effort to transition the Nation's care providers to modern technology to the clear imperative of shifting from a costly fee-for-service model to value-based delivery payment structures, we have collectively resolved to tackle a series of very difficult complex problems, all with the idea of reducing costs and taking better care of patients. To cite just one particularly timely example, the 21st Century Cures package of initiatives championed by many on this committee has tremendous potential to improve health care, but many of its components assume and depend upon continued technological evolution.

I am not here to tell you that ICD-10 is a silver bullet, but on the spectrum of the challenges we face in health care, ICD-10 is a relatively easy one, the technological equivalent of an upgrade from a simple dictionary to a more complex one. It will be orders of magnitude less difficult than achieving the changes in human behavior necessary for the Meaningful Use program to succeed

or implementing the fundamental evolution in health care business models necessary for truly accountable care. Repeatedly delaying the implementation of relatively simple changes calls into question whether we as a country are truly committed to improving health care and potentially undermines the success of our national health care agenda.

Fortunately, we know that ICD-10 is absolutely possible. Much of the developed world has made the switch years ago including, for example, the Czech Republic, Korea and Thailand, where, according to the World Bank, the average annual health care spend per capita is $215 compared to nearly $9,000 in the United States.

At athenahealth, we have already completed the work necessary to ensure that our clients were ready for last year's deadline as they will be ready for this year's. In fact, we financially guarantee ICD-10 readiness for each of our tens of thousands of clients. We are not the only solution.

Many of our clients practice in exactly the kinds of small medical groups that have expressed significant concerns about the changes required to adapt to ICD-10. Each new

delay only multiplies the financial and emotional cost of such practices, who struggle not only with the implications of a possible code switch but with the persistent uncertainty created by repeated delays. Fear creates stasis, inhibiting progress not only on ICD-10 but also on the other more important systemic reforms that I discussed a few moments ago.

Athenahealth clients have no reason to fear. Because we are Internet based, we will throw a virtual switch at the moment ICD-10 requirement goes into effect, and every one of our clients will be upgraded at that same moment.

There is a solution to the perceived ICD-10 problem, and we certainly are not the only ones that can provide it. Repeated delays of supposedly firm deadlines both in ICD-10 and in other health IT programs like Meaningful Use make it all too easy for some in our industry to doubt future deadlines. Delays unintentionally create incentives for some vendors to forego the work necessary to prepare for ICD-10, confident that their failure to prepare will not harm their clients because we will continue to kick the can and not really move forward with reforms necessary to improve

efficiency and patient care. This is a damage cycle of non-performance that will only be broken when the government resolves to stick to the deadlines it communicates.

Either ICD-10 is worth doing or it is not. If it is, then stick to the deadline this year. There will be some disruption but our industry and the Nation's care providers will respond and adapt. If you conclude that the benefits of ICD-10 do not outweigh the potential risks, then cancel the program and focus legislation more aggressively on the few fundamental changes in health care that are necessary to cure our current dysfunctional system.

On behalf of athenahealth's 60,000-plus care provider clients and their many thousands of colleagues, I urge you in the strongest possible terms, do not again kick this can down the road. Pull the trigger or pull the plug.

Thank you.

[The prepared statement of Ms. Matus follows:]

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Mr. {Pitts.} The chair thanks the gentlelady and now recognizes Ms. Bocchino 5 minutes for your opening statement.

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^STATEMENT OF CARMELLA BOCCHINO

} Ms. {Bocchino.} Thank you. Good morning, Chairman Pitts and Ranking Member Green and members of the subcommittee. I am Carmella Bocchino, Executive Vice President of America's Health Insurance Plans, the trade association for the health insurance industry. I appreciate the opportunity to testify about the importance of implementing the ICD-10 system on October 1st without any further delay.

I think everyone here today agrees that we need more value in our Nation's health care dollar and we need a 21st century health care system. To support this goal, our members believe it is critically important for the health care system to move forward now with the ICD system to deliver greater value for consumers and improvements in quality improvement, and implementing ICD-10 under the current timetable will establish a strong foundation for allowing health plans and providers to identify and report conditions and medical treatments in more specific ways,

ultimately leading to more effective measures of quality and health outcomes.

Delaying implementation will increase cost and impose significant administrative challenges across the entire health care system. Our industry processes millions of claims, eligibility requests, payments and other administrative and clinical transactions on a daily basis. Recognizing the migration to the ICD-10 code set has a major impact on all these activities. Our members have devoted a tremendous amount of time and resources to be ready by October 1, 2015. This includes extended outreach to health care providers as well as their vendors, working with them to provide education and implementation tools, crosswalks, practice management upgrades, and instructions and appropriate coding based on the provider's area of practice.

Our written testimony provides specific examples of steps many of our members are taking to prepare for ICD-10 implementation. For example, completed internal systems testing to assure successful use of ICD-10 on all claims and other transactions and engage with providers, hospitals and physician groups and their vendors to do this external

testing, ensuring end-to-end testing of submitted claims. We have conducted readiness surveys to assess partners' familiarity with the coding system and the expected process for submitting compliant transactions and to see what support is continued to be needed, developed informational articles and resource materials that provide detailed information for health care providers on ICD-10 and how to incorporate the new coding system into their practices. They have updated clinical policies to reflect the new ICD-10 codes and provided this information to their health care provider partners. And some members have actually established a professional readiness portal for ICD-10 that allows hospitals, medical group systems, clearinghouses and individual providers to engage in testing and check their own readiness by submitting claims based on specific episode-of-care scenarios. These activities have been supplemented by significant efforts undertaken by HHS Road to 10 Initiative and private stakeholders as the American Health Information Management Association, many professional societies and others.

From a quality improvement perspective, ICD code sets

provide substantial more specificity and precision in defining a diagnosis or procedure. It will make it easier for health care providers and researchers to identify the correct code for a diagnosis or procedure and document medical applications. This expanded detail compared to the ICD-9 system is a fundamental building block for payment reform and will enable providers and payers to track health outcomes more effectively.

Because the ICD-10 system offers more granularity to identify disease, public health surveillance will be better equipped to analyze and interpret data, thereby providing early warning signals for impending public health emergencies, monitoring the epidemiology of public health problems, and informing public health policy.

In closing, I want to note that ICD-10 already has been delayed three times, as has already been stated. Another delay would bring significant cost and additional administrative challenges for health plans and providers that have been and are ready to implement, penalizing those who have invested the time and resources necessary to implement on time. Further delays also would prevent providers and

payers from leveraging ICD-10 to improve patient care and quality outcomes.

Without the more accurate, reliable data that will be facilitated by ICD-10, ongoing efforts to a transition to a payment system based on quality and outcomes would not achieve their full potential. These outcomes both in terms of financial cost and lost opportunities are unacceptable.

For that reason, we strongly urge the committee to support the current schedule of implementing ICD-10 codes on October 1st.

[The prepared statement of Ms. Bocchino follows:]

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Mr. {Pitts.} The chair thanks the gentlelady and now recognizes Dr. Terry 5 minutes for your summary.

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^STATEMENT OF WILLIAM JEFFERSON TERRY

} Dr. {Terry.} Chairman Pitts, Ranking Member Green, members of the subcommittee, my name is Dr. Jeff Terry, and I am testifying today as a member of the American Urological Association and as a practicing urologist who puts in 13 hours a day taking care of patients in Mobile, Alabama. We thank you for this hearing very much.

The AUA has a membership of 18,000 physicians and is also a member of the Alliance of Specialty Medicine. During the last Congress, I had the privilege of moderating an Alliance roundtable on ICD-10 where members of CMS were actually present.

The AUA enters this debate on ICD-10 as an advocate for the patients and the physicians. As you hear testimony today, keep in mind the concerns of practicing physicians who want to preserve the all-important patient-physician relationship and don't put the computer and statistics in the middle of this relationship.

I know that you will weigh any proven patient care

advantages of ICD-10 against the consequences of a flawed implementation. Ultimately, the benefits should outweigh the risks.

The ICD system was designed for the purposes of gathering statistical and epidemiological data. The United States is the only country that uses it as part of the billing system. ICD-10 is planned to replace ICD-9 all in one day. Our present system has 13,000 codes where ICD-10 will have anywhere between 68,000 and 87,000 codes, and the United States is the only country that uses all of these codes. The other countries use about a fifth of that number. Experts estimate physicians should plan on a 3 to 4 percent increase in time per patient encounter merely to document the correct code. The coding guidelines for ICD-10 are more complex, and those who do not fully understand them will fail to document correctly and not be paid.

Proponents of ICD-10 say the increased specificity will improve clinical data and improve quality. These potential benefits are not documented. However, the cost of ICD-10 is well documented for physicians who already face increased cost in complying with EHR incentive programs, the PQRS

Quality program, the Value-Based Payment Modifier Program, not to mention the annual threat of SGR cuts and the 2 percent sequestration cut that we already have.

Now we are faced with the costly unfunded mandate of ICD-10 that will certainly put some physicians out of business. Physicians are overwhelmed with the tsunami of regulations that have significantly increased the work for our practices. Physicians are retiring early, which could leave countless number of patients without a doctor. Based on data in other countries, all physicians will be forced to reduce the number of patients that they see when ICD-10 is implemented, which can last for more than a year, resulting in less efficient practices and making it difficult for patients to get the care they need.

An independent study last year found significant cost associated with upgrading the hardware, the software, the training of personnel and the conversion of ICD-10 ranging from $50,000 to $250,000 for small practices and several million dollars for large practices. CMS states that physician consider getting a line of credit to cover cash-flow problems and expenses. Others have suggested the need

for a 3- to 6-month cushion. This is not possible for most practices that have very few assets to quality for these significant loans.

While CMS is in the midst of end-to-end testing, it is primarily being conducted by volunteers who are prepared. We worry that these results do not paint an accurate picture of the current state of provider readiness.

Ladies and gentlemen, no matter what the coalition or the coding industry says, the vast majority of America's physicians in private practice are not prepared for this ICD implementation all in one day. The continual threat of Medicare payment reductions, the time-consuming CMS quality programs, the new EHR systems, Medicare compliance programs occupy physicians so much that they don't have the time or resources to prepare for ICD-10. It is harder and harder to keep the patient as the primary focus in our daily activities. ICD-10 is viewed as another expensive distraction with little demonstrated value to improving patient care. The huge costs certainly outweigh the very few benefits as far as patient care is concerned.

Our focus today is not centered solely on the financial

investment made by large health insurers, health systems and other entities preparing for this transition. Our focus is about our government providing an environment where physicians and health care professionals can devote all of their energies to medical issues for the benefit of their patients. To that end, I urge Congress to delay implementation of ICD-10 and appoint a committee to better study the risks and the benefits with the patient in mind. If a delay is not possible, then consider a dual ICD-10 option permitting physicians to make the transition so we can survive in our practices.

Thank you so much for your commitment and your leadership on this issue. ICD-11 is probably 5 years away so we need a policy for appropriate coding transitions in order to avoid this problem again.

I am happy to answer any questions that you see fit.

[The prepared statement of Dr. Terry follows:]

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Mr. {Pitts.} The chair thanks the gentleman and now recognizes Dr. Hughes 5 minutes for your opening statement.

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^STATEMENT OF JOHN HUGHES

} Dr. {Hughes.} Thank you, sir. Mr. Chairman and members of the committee, first let me just interject that I very respectfully appreciate Dr. Terry's comments about the stresses of the regulatory burden placed on physicians, but I would offer that ICD-10 is not the major problem and is probably a trivial problem compared to the other issues that confront practices today.

I am a general internist. I am Professor of Medicine. I teach medical students and medical residents. I see patients on my own and I conduct research in areas of quality assurance.

One of the research areas I have focused on is the study of complications of care, with the view that if we can accurately identify the factors and circumstances that account for complications, then we will be able to reduce their occurrence. In fact, several States, Maryland for one, are now adjusting hospital payments based on some of this research.

The usefulness and reliability of this kind of research depends very much on how precisely we can identify the specifics of the complication and exactly how they are treated. Although we have made considerable progress in addressing complications, other quality issues in the past several years, complication rates remain unacceptably high. The ICD-9 coding system fails to provide the level of detail needed to expand these efforts. I have been personally frustrated many times at ICD-9's inability to specify the exact nature of a complication, its extent, its location, and how it was treated.

Now, as an example, let me ask you to consider a 74-year-old man who fell, sustaining a puncture wound that severed his left femoral artery. He was rushed to surgery, where the damaged portion of the artery was replaced with a synthetic graft. These events are coded in ICD-9 as a diagnosis of ``injury to the common femoral artery'' and the procedure code is ``resection of vessel with replacement.'' There is no mention that the injury was a major laceration on the left side, or that the type of replacement was a synthetic graft, all of which is included in the ICD-1.

This lack of detail is even more obvious when it comes to complications. Consider the same man developed bleeding at the site of the graft on the day after surgery. He was returned to the operating room, his incision was reopened and the graft repaired at the site of the leak. ICD-9 codes this as ``mechanical complication of other vascular device or implant or graft'' and the procedure code is ``revision of vascular procedure.'' So all we know is that there has been some type of complication that required some type of surgery, and that is about it. The ICD-10 code provides a much more complete picture, telling us that the complication was a hemorrhage, exactly where it occurred, and that the revision was a re-suture of the graft using an open approach. This is but one example. There are numerous throughout the ICD-9 system, and the benefits of the ICD-10 providing the extra detail.

Another major flaw in ICD-9 is that it does not have the capacity to expand to provide new codes describing new treatments and technologies. This means that new techniques such as minimally invasive surgery, which have been increasingly and successfully used in cardiac surgery, and

are rapidly expanding into other surgical fields, cannot be adequately described using the simplistic four-digit and sometimes five-digit structure of ICD-9. Minimally invasive surgeries use smaller incisions, which results in fewer complications, less discomfort, more rapid healing and shorter hospital stays.

Now, we don't need ICD-10 in order to do minimally invasive surgery but these new procedures will not be adequately described if we continue to use ICD-9. They will have to be described in general terms or they will have to be included in codes that contain open surgical approaches, resulting in insufficient detail to track their increasing use.

The structure of ICD-10 allows this important information to be captured in a systematic manner, and can be readily expanded to incorporate descriptions of new discoveries and treatments when they become available. This capacity is critical to track and assess the efficacy of these new technologies.

Thank you very much.

[The prepared statement of Dr. Hughes follows:]

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

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Mr. {Pitts.} The chair thanks the gentleman. Thank you all for that excellent testimony. I will begin the questioning and recognize myself for 5 minutes for that purpose.

I would like to ask a series of questions to all of you, so please respond yes or no to these, and we will just go down the line. We will start with you, Dr. Burke.

In your opinion, do you believe we are ready for ICD-10 implementation, yes or no?

Dr. {Burke.} Yes.

Mr. {Pitts.} Mr. Averill?

Mr. {Averill.} Yes.

Mr. {Pitts.} Ms. Bowman?

Ms. {Bowman.} Yes.

Mr. {Pitts.} Ms. Matus?

Ms. {Matus.} Yes.

Mr. {Pitts.} Ms. Bocchino?

Ms. {Bocchino.} Yes.

Mr. {Pitts.} Dr. Terry?

Dr. {Terry.} No.

Mr. {Pitts.} Dr. Hughes?

Dr. {Hughes.} Yes, sir.

Mr. {Pitts.} All right. Thank you. Again, all of you, in your opinion, should Congress oppose attempts to delay ICD-10 implementation? Dr. Burke?

Dr. {Burke.} No.

Mr. {Averill.} It was a double negative.

Mr. {Pitts.} Let me repeat the question. In your opinion, should Congress oppose attempts to delay ICD-10 implementation?

Mr. {Averill.} They should oppose.

Mr. {Pitts.} Yes. Okay.

Ms. Bowman?

Ms. {Bowman.} Yes.

Mr. {Pitts.} Ms. Matus?

Ms. {Matus.} Yes.

Mr. {Pitts.} Mrs. Bocchino?

Ms. {Bocchino.} Yes.

Mr. {Pitts.} Dr. Terry?

Dr. {Terry.} No, sir.

Mr. {Pitts.} Dr. Hughes?

Dr. {Hughes.} Yes.

Mr. {Pitts.} All right. Again, down the line, Dr. Burke, we will start with you. In your opinion, what impact would delay have on your industry and the patients you serve? You can elaborate a little bit.

Dr. {Burke.} Well, I think, you know, the ICD-10 is a very good communication tool. Either you can use the ICD-10 code or you would have to use it in your plan. You would have to type out everything in your plan, so actually it flows a lot more smoothly.

Mr. {Pitts.} Okay. What impact would delay have on your industry or patients you serve, Mr. Averill?

Mr. {Averill.} Well, certainly it would dramatically increase the cost of being prepared to ultimately move forward. It would also continue to compromise our national data in terms of having the necessary information to evaluate many of the things that the panel talked about, and so what is most concerning to me is the dramatic increase in cost of any delay.

Mr. {Pitts.} Mrs. Bowman?

Ms. {Bowman.} I would say certainly the cost. Our

members are health management professionals who have been trained and retrained and have to keep their training updated to maintain their skills for whenever ICD-10 is implemented so the cost and also I would agree with Rich's comment about the delay and being able to use the better delay.

Mr. {Pitts.} Mrs. Matus?

Ms. {Matus.} Countless care providers, hospitals and other institutions have already been untold thousands of dollars into preparing for ICD-10, so those are the hard costs. The soft costs of, you know, the uncertainty which is magnified by each delay is unquantifiable.

Mr. {Pitts.} Mrs. Bocchino?

Ms. {Bocchino.} So I will echo what others have said but I will also add that a lot of times additional documentation is required by providers under ICD-9 in order to process a claim. Because of the specificity of the ICD-10 codes, much of that documentation will go away and therefore we believe it will actually reduce some of the burden on providers.

Mr. {Pitts.} Dr. Terry?

Dr. {Terry.} I know I am in the minority on this panel

but I want you to know, I represent thousands of doctors. Speaker Boehner has four boxes of thousands of letters in his office on this subject. I have some at the table.

You know where I stand. It has the potential to do irreparable harm to the patients and the physicians who can't implement this the way industry wants us to. You know, we don't treat by statistics. I mean, this is just something that gets in our way of taking care of our patients, and it has to be done the right way.

Mr. {Pitts.} All right. Dr. Hughes, what impact would delay have on your industry or patients you serve?

Dr. {Hughes.} I agree that this has to be done in the right way. Delay means a couple things. One, if physicians are interested in keeping up with what is happening and learning the effectiveness of new treatments, we need to have better data. So that will--if we don't implement this, we are not going to be having the optimum amount of data.

Mr. {Pitts.} All right. We are going to have to keep going. I have a couple more questions.

Dr. Burke, does ICD-10 bring any value to the patient community? It is one thing to improve systems operations for

insurers and hospitals but how does this matter to patients?

Dr. {Burke.} I think, you know, for instance, if you use an ICD-9 code and a patient calls a couple days later, like if they come in with leg pain, you know which leg it is. You will have to ask them again where their pain was, but if you use an ICD-10 code, you can actually localize the pain to either extremity. So it is a lot better communication tool.

Mr. {Pitts.} Now, we heard a little bit mentioned about ICD-11. Ms. Matus, what are your thoughts on, you know, just wait for it instead of forcing people to go through ICD-10?

Ms. {Matus.} So, you know, again, we think this is either important to do or it is not. If we were convinced that the United States that we as a group would take a leadership position in moving forward with ICD-11, then maybe miss ICD-10. But without a firm commitment to be the leaders in a new coding methodology that is still 5 years away and frankly needed today, that seems like a bridge too far.

Mr. {Pitts.} All right. My time is expired. Let me make it clear as chairman of this subcommittee, I support ICD-10, moving forward to ICD-10 rather than another delay. We need to end the uncertainty, in my opinion, move forward

to full implementation of ICD-10.

At this time I will recognize the Ranking Member, Mr. Green, 5 minutes for questioning.

Mr. {Green.} Thank you, Mr. Chairman. I would like to ask unanimous consent to submit for the record the article showing ICD-10 implementation cost in small physician practices are dramatically lower than expected.

Mr. {Pitts.} Without objection, so ordered.

[The information follows:]

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Mr. {Green.} Thank you, Mr. Chairman.

Dr. Terry, I know that you, coming from Texas, you probably feel like you are the Alamo.

Dr. {Terry.} I have my Kevlar suit on.

Mr. {Green.} And I appreciate urologists. I work a lot like all of our committee members on the committee work a lot with our specialties because delivery of health care. The biggest issue I hear from them is not ICD and obviously it is SGR, and I have served with some really great members from Mobile. You have a beautiful city. Sonny Callahan was a good friend and Joe Bonner, and you have a history of sending good hardworking Members to Congress from Mobile.

Mr. Averill, you mentioned that ICD-10 testing is still ongoing. For those who are preparing the transition, do you expect ICD-10 implementation to run smoothly come October 1st?

Mr. {Averill.} Yes, I do. I think there has been extensive opportunity both on the commercial payer side and the CMS side to do end-to-end testing. CMS has a whole series of end-to-end opportunities for those who are prepared

and are willing to participate.

I want to emphasize that for CMS, this is a relatively routine update to their claims processing system. This is their core competency. I submitted in my testimony that they have had some difficulties with consumer-facing websites but this is their core competency, namely updating the claims processing system.

Mr. {Green.} Well, I hope they are doing some run-throughs before October 1st so we don't have what we had when some of us wanted the Affordable Care Act to roll out much more easily.

What about those folks who haven't begun to prepare for transition? Can they still be ready by October 1st? Here we are in February.

Mr. {Averill.} I have been very impressed with how the market has responded with educational material out there, much of it for free. The market has really responded. Most vendors have converted their systems to ICD-10 and are by and large making that available to their clients for free, and so the whole infrastructure is there on a much more sophisticated basis than it was even 1 or 2 years ago, so I

remain confident that those who are lagging behind at this particular point in time if they are willing to expend some effort to get prepared, those resources are readily available.

Mr. {Green.} I have another question for you, and I only have a couple minutes left. You testified the effect of the current ICD-9 coding system with diagnostic related groups, or DRGs. DRGs are used to classify hospital cases into groups for the purpose of reimbursement. Does the fact that ICD-10 is almost 40 years old have an effect on DRGs?

Mr. {Averill.} Absolutely. As I said, it is not uncommon to have reasonable requests from the industry suggesting an MS DRG change. Very often if you look at the Federal Register, you will see CMS saying we had this suggestion, unfortunately we weren't able to evaluate it because there is no ICD-9 codes to evaluate that particular aspect.

Mr. {Green.} Who is most affected if the DRGs aren't modified property?

Mr. {Averill.} Well, I think the whole industry is-- hospitals' financial viability, reputations of individual

institutions because they are often used for evaluating--or a component of evaluating quality of care. I think it is pervasive throughout the industry. It is absolutely critical that we keep MS DRGs up-to-date and reflective of today's medicine.

Mr. {Green.} Ms. Bowman, what types of training and resources go into preparing for ICD implementation and what is the cost of delaying?

Ms. {Bowman.} The cost of the training that goes into implementation has to do primarily with training coders on using the code sets and other users in understanding what the changes in the data are going to look like after the code sets are implemented, and also changes to systems and those personnel in understanding what changes need to be made.

Also, a big factor is clinical documentation improvement, and so I would say the biggest factors are probably training coders and then training physicians on improving their clinical documentation, but we found that there is a growing marketplace for tools in helping with the clinical documentation improvement because ICD-10 actually lends itself better because of its logic and specificity for

those types of tools so that is turning out to be not as burdensome as some had feared initially.

Mr. {Green.} Thank you, Mr. Chairman.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the Chair Emeritus of the full committee, Mr. Barton of Texas.

Mr. {Barton.} I thank you, Mr. Chairman, and I appreciate you holding this hearing. I think it is good to have transparency.

I would point out, in our memo for this hearing, we have a coding error. The memo talks about that the International Statistical Institute began in 1891 to begin the process of creating an internationally recognized classification of diseases. That is pretty cool. A hundred and 16 years ago they started doing that, so we have our own coding problems on the committee staff.

But in any event, I think it is pretty obvious when the committee chair or the subcommittee chairman says that he supports this, and he is the chairman, and the Ranking Member seems to support it, that we are supportive. I haven't had a chance to talk to either of those gentlemen, and I am not

opposed to going to ICD-10 but I do have some concerns, and they are more at the CMS level than the panel, but I don't see why it has to be an either/or. I don't see why CMS has to arbitrarily say this is going to be the way it is come hell or high water.

I don't know enough about the coding systems and the computer programs and all that. I would have thought that ICD-10 would build on ICD-9 and that they would be compatible so that you didn't have to choose. Dr. Terry, is that not true? I mean, are they so different that you couldn't use either one or the other?

Dr. {Terry.} Well, the codes are very different. Yes, sir, they don't--I mean, it is just not an exponential increase in the codes but it is a mindset. It is different rules. It is just totally different.

Mr. {Barton.} I don't have my Congressional phone with me. This is my campaign phone. It is an iPhone. My Congressional phone is still a BlackBerry, and nobody made me switch to this phone for campaign purposes. As all the members up here know, we have to separate our campaign communications from our Congressional, and the iPhone seemed

to be better, and so that is what the campaign bought. But there is no FEC law that says I have to. If I still wanted to use a BlackBerry on the campaign, I could.

I will ask the doctor on the end here, I can't see your nameplate, sir, but I listened to you. Why couldn't CMS provide incentives to switch to--our Medicare, for that matter--to switch to ICD-10 by payments, but if a family practitioner or a doctor in a small practice didn't have the money or didn't want to, you know, let them use ICD-9 and not--they might not be reimbursed as much but they could still get something, and if you were in a more specialized practice that needed more complicated codes, do it that way so it is not an either/or.

Dr. {Hughes.} I am not a health economist or an administrator. The idea of incentives is inherently appealing to me, but I don't know, it seems to me like that would cause lots of duplication of effort on the part of CMS, which might be prohibitively expensive, but that is just a question I am raising. I can't answer that question definitely. Some of the other folks on the panel may be able to.

Mr. {Barton.} Well, my point is, you know, you can make things happen by punitive measures or you can make things happen by incentives, and in this case, it looks like we are trying to be punitive by saying no matter what, you have to do it, and I don't know for the life of me if I am in whatever business I am in, if I want to conduct my business on way, I know I may be penalized by not being reimbursed as much or not getting as timely a payment or something, but you know, I don't know why we have to force people into a system that for whatever purpose they just don't feel like they are ready to go to.

Dr. Burke, do you have any comments on that?

Dr. {Burke.} I would say just in general, I mean, ICD-10 is a lot better program than ICD-9. I mean, it makes it easier to find the diagnosis, so actually would probably spend less time in the room with the patient with an ICD-9 code.

Mr. {Barton.} Well, from an insurance perspective and from a data information perspective, I agree with you, it is more specific and all that, but from a practitioner perspective, I am not sure that I am following that. I would

like to see CMS work with the user community at the provider level and come up with a way to incentive it without telling them they had to do it.

With that, Mr. Chairman, my time is expired and I yield back.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the lady from Florida, Ms. Castor, 5 minutes for questions.

Ms. {Castor.} Well, thank you very much, Mr. Chairman, and thank you to our experts for your testimony here today.

So what I understand is the International Classification of Diseases coding system number 9 has been in place in the United States since 1979. In 1990, a new classification system, number 10, was adopted. In 1996, the Congress gave general direction for the United States to move towards that coding system. While the United States has delayed it for many, many years, 38 other countries have transitioned to that modern ICD-10 coding system.

The United States is typically a world leader but it appears that unfortunately that is not the case when it comes to the modern coding system, and the problem is that based on

all the evidence I have seen, that has been very costly for our country and for practitioners. A number of studies have concluded--HHS did an analysis in 2014, the RAND Corporation did an analysis, and we are working about billions of dollars in the American health care system, and many of you have testified today about the cost. So I would like to join my colleagues in urging no more delays in the transition to ICD-10, and especially I urge the leadership not to include delays in must-pass bills, especially something as important as how we pay doctors that see Medicare patients. Let us stick with the October 1st deadline.

Another reason is since 1979, think about the changes in health care that has been mentioned today. New medical devices, new treatments have been developed, and our coding system has to reflect modern medicine. The consensus, as I understand it, is more specific codes will help us make great strides in health care quality, and all of you have mentioned how important it is for America to transition from paying for quantity of care to quality of care, and it appears to me that more specific data will help payers implement incentives for better patient outcomes. Better specificity will help

the providers who we are increasingly holding accountable for patient safety, readmission rates, patient outcomes.

So I would like to focus on a couple of things. I also heard Dr. Hughes testify that the change in the codes will be important to improvements in research, the importance of identifying factors and circumstances that account for complications of care in order to reduce their occurrence. Can you talk a bit more about how ICD-10 will help with research initiatives?

Dr. {Hughes.} The kind of research that I do and many other people do in attempts to improve quality all depends on data. That is what is needed. It has to be accurately recorded. It has to be precise enough that actually makes some difference, that it is specific enough, and with specific-enough data, you can track patterns, you can track the introduction of new procedures, and all that makes the quality of the research much better and makes the results more accurate.

Ms. {Castor.} How does it make the quality much better in the long run?

Dr. {Hughes.} Well, because you are able to identify

specific actions, you are able to identify specific new procedures. When you have a new type of minimally invasive procedure, for example, you don't have to categorize that as another open procedure or ICD-9 to categorize those new procedures as other types of cardiac surgery.

Ms. {Castor.} What type of diseases are you talking about?

Dr. {Hughes.} Well, here I am talking about cardiac surgery on the procedure side, but the new procedures are being expanded into gastrointestinal surgery, to lung surgery, you name it. There are illnesses on the diagnosis side. There are illnesses that arise or illnesses that differentiate. We have new categories of malignancies.

Now, you can always add an ICD-9 code but at this point we are pretty full. ICD-9 really has not that many more codes that you can cram new information into so you have to add a code that is out of--you know, put it in a different chapter or you have to lump it in with a whole lot of other things. So the specificity can make a whole lot of difference in terms of tracking illness and tracking new interventions.

Ms. {Castor.} Thank you very much.

Mr. {Pitts.} The chair thanks the gentlelady and now recognize the Vice Chair of the Committee, the gentleman from Kentucky, Mr. Guthrie, 5 minutes for questions.

Mr. {Guthrie.} Thank you, Mr. Chairman, and I want to start with Dr. Burke.

I have talked to different people about ICD-10 conversion, and we went to estimate to cost to implement this, as much as $84,000 and as low as a few thousand dollars. Could you help the committee understand what actual costs are faced by the doctors' offices as we move forward?

Dr. {Burke.} That is a good question. I don't know, because for us, it didn't cost anything. You know, it was just another day in the office, you know. Day one we were using ICD-9, the next day we were using ICD-10.

Mr. {Guthrie.} No cost to transfer over?

Dr. {Burke.} No, no. Our software vendor was the primary factor in getting that done but, you know, there is no cost to us.

Mr. {Guthrie.} Well, thanks.

And Dr. Terry, I will get to you in a second on that. I

have got a question.

There was a new GAO report out Friday, and it finds that while some concerns persist--and a unanimous consent to enter this into the record.

Mr. {Pitts.} Without objection, so ordered.

[The information follows:]

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Mr. {Guthrie.} It said that CMS has done notable work to address concerns, providing educational tools, opportunities for testing, and Ms. Bocchino, is it your belief that resources and testing are available to those who want to be ready by October?

Ms. {Bocchino.} Absolutely. And if I can make one other comment, they are providing all kinds of outreach and educational testing as well as end-to-end testing with claims and getting providers accustomed to the new.

I also want to comment that running dual systems is just not feasible, even on the private-sector side. It is very costly, and what the plans are going to be doing on October 1st is they are going to be switching to new clinical policies and new algorithms based on the new codes, and having two tracks will just create more confusion for providers as well as for payers. It is important to send a very strong message that we are going to implement on October 1st.

Mr. {Guthrie.} I want to talk to all the panelists but I want Dr. Terry to go first, give you an opportunity. I

married an Alabamian, so I appreciate your accent very well. My dear wife is from the Shoals.

My question, well, there has been delays going on--well, first of all, I appreciate your concern because I know as things change in administration and health care and the Affordable Care Act, it seems to smaller individual or small personal practice, this is a bigger practice and a hospital has more administrative ability to cover their overhead, and we understand that. And also you have--Mr. Barton talked about it--I just switched to an iPhone. The reason I didn't for so long is because of the cost, time costs more than anything, but it was my decision because I was paying for it and my time just sit down and really learn how. I know how to use the BlackBerry. And so the difference was, it was really my decision because I was--although people in Medicare pay through payroll taxes, they pay through their taxes, they pay for their health care but it goes through a third party. And so as we try to get information on what is being paid for, controlling costs of what is being paid for, that information is important to the people paying for it, which is really the taxpayer overall, so I understand your issues

moving forward. And so the question is, with the GAO, the resources, I will start with Dr. Terry and all the others, we have had two delays administratively, one Congressionally. I mean, in the meantime, you see it coming, and what have you all been doing, people with practices that are smaller than hospitals or megapractices been doing to move forward knowing it is coming?

Dr. {Terry.} Well, it has been entered into the record. We sent an attachment, the study that was done by an independent group a year ago that shows the costs that I quoted in my testimony, and that is true for my practice. We paid enormous costs to our computer people just to put the thing in. Some people have contracts and they don't have to pay the cost. We paid a lot of money, and if you send people off to--if you sent me off to a course to learn how to do it, that is more than $5,000 right there.

Mr. {Guthrie.} Plus your time.

Dr. {Terry.} So the cost--but we are not here to debate that, and we are not here to debate--I think to continue to delay it is not the right answer. Now, you are surprised I said that. You can delay, delay, delay but whenever that

time certain date is, we are still not going to be ready, and it is because it is a flawed implementation. It is a big buying approach all in one day. The industry says it takes a year to get ready for this. How can you spend the time and effort and resources to prepare for something that is a year away when you don't know what it is going to do and then you don't even know when they turn the switch if it is going to work?

We need a transition. The problem here is the implementation. Now, I can argue the product, why are using 80,000 codes, the rest of the world 20. How can we compare data with the rest of the world when we have 80,000 codes and they have 20? How do those compare? But the problem here is the implementation, and it needs to be some kind of transition we have to figure out.

Now, the dual system, I have heard CMS say they can't do it. I heard the Blue Cross Blue Shield man yesterday at the ICD coalition meeting say they are already doing it. So it can be done, and I don't know if that is the best thing to do, but we have to--physicians have to have a guarantee that we are going to get paid if we don't code right.

Now, remember, why does coding have anything to do with how we get paid? We provide a service, and you are not going to pay me because I coded wrong? Everybody can't run a 4-minute mile. Some doctors aren't going to be able to do it, and do they deserve the death sentence and be put out of business?

Mr. {Guthrie.} I understand your concern with that, I do. I appreciate it. Thank you.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentleman from Oregon, Mr. Schrader, 5 minutes for questions.

Mr. {Schrader.} Thank you, Mr. Chairman. I appreciate the opportunity. I appreciate the opportunity for the hearing.

I guess, Dr. Burke, first question is, how many additional codes did you feel you had to deal with in your practice compared to ICD-9?

Dr. {Burke.} Not many more. I would say maybe 10 or 20 percent more.

Mr. {Schrader.} Okay. Then for Ms. Bowman, I guess, are there tables out there that would help private

practitioners figure out what additional costs they are going to have to use? In other words, if you are a urologist, is there a set of codes you can handily go to or is this all done alphabetically and you have to figure out what code out of the list of 10,000 is going to fit your particular situation?

Ms. {Bowman.} Well, the classification itself is organized by body system chapter, so the different specialties are typically organized together, and a lot of the medical specialty societies have developed cheat-sheet resources for their members on the codes typically used in that community.

Mr. {Schrader.} So Dr. Terry, would you agree on this one point, anyway, that there is an ability to figure out what codes are relevant to your particular style of practice?

Dr. {Terry.} Well, sure. One of the comments is that I am only going to have 50 or 60 codes as a urologist, but there are unintended consequences here, and Blue Cross Blue Shield of Alabama makes me code 10 diagnoses for every patient encounter, so I have a patient with a kidney stone, I can code that easily, but I have to code their diabetes,

their coronary artery disease, their high blood pressure. Diabetes has 250 codes, and if I don't do that, then Blue Cross--we are talking about Medicare and CMS, but guess what? We get paid by Blue Cross and United Health Care and Aetna, and it is going to kill me. I can't sit there and go through all those codes.

Mr. {Schrader.} Ms. Bowman again, what do you see the role of ICD-10 versus ICD-9 in combating fraud and, you know, abuse of coding, if you will, that occasionally goes on by the very few practices?

Ms. {Bowman.} For a lot of the same reasons that Dr. Hughes mentioned as the benefits of the specificity, it actually will help prevent and detect fraud, because right now there are so many services or diagnoses that are lumped into the same code, sometimes those that are covered and non-covered services are lumped into the same code. So as I often describe in some of my presentations, you can kind of hide behind the gray areas of ICD-9 whereas ICD-10, the specificity is such that it is black and white. The documentation should support what the specificity of that code is, and it should be much clearer, both to the provider

in trying to assign the right code and the auditor or payer trying to determine that the correct code has been assigned.

Mr. {Schrader.} Okay. I guess, Ms. Bocchino, when they talk about cost, there seems to be disagreement. It is a relative level of costs that a practice or a hospital or provider would incur. There are different styles of practice, and medicine is changing. Even in my little veterinary medical world, our practice has changed dramatically in the last 35 years. Could you comment a little bit about the contrasting views we have heard today about the cost to the practice?

Ms. {Bocchino.} I think a lot of it has to do with the contracts they have with vendors as actually Dr. Terry did mention, and if they are doing a lot of this internally and not using vendors externally, a lot of it is, do they have their own systems that they would have to go in and pay the cost of upgrading their own systems versus working with a particular vendor who is going to be responsible for all that upgrade, and it is just embedded in the contract. Also, some of the studies are more current now and so we have gotten more data on cost as more and more practices, particularly

small practices, have begun the transition to ICD-10, and to comment on what Dr. Terry said before, right now some of the plans are using dual systems because some of the providers have converted over to ICD-10, but that has to stop because they are losing money on the additional costs that they have to put in to have both systems. This can't go on forever.

Mr. {Schrader.} I guess, Dr. Terry, last question for me anyway would be, you know, the system is changing. It used to be--I was a veterinarian. I just provided a service and I knew I was doing a good job. My patients got better. My clients were satisfied at the end of the day. But medicine in general seems to be moving to a more value-based outcome system. It is very different than my fee-for-service system. And frankly, we are asking the government and the taxpayer to fund a lot of this stuff.

So what is your thinking on, you know, the evolution of medicine here? I mean, you and I are a little older than some of the young bucks coming up these days, and they are going to the computer to figure out what the diagnosis is and stuff as much as relying on their own instincts. How does the movement to value-based medicine affect our view of this

coding system?

Dr. {Terry.} Well, you are right, I am a dinosaur but I know how to turn on a computer.

Mr. {Schrader.} I do too.

Dr. {Terry.} You just opened up a whole other can of worms, what I think bout value-based payment. We don't even know how to define value, okay, so how can you pay for value when we can't even define it? You know how as a patient if my treatment is valuable but how is the government going to define it? I am not going to go there, but that is the problem with it.

You know, they talk about these statistics but, you know, in medicine, we have something called the scientific method, and it is not statistics. These codes are for statistics, not for research. Now, you can do statistical research but you can't do medical research. It is not the scientific method. So I have concerns about some of the amendments and argue of the benefits of all of this.

Mr. {Schrader.} Thank you, and I yield back.

Mr. {Pitts.} The chair thanks the gentleman and recognizes Dr. Burgess 5 minutes for questions.

Mr. {Burgess.} Thank you, Mr. Chairman, and again, I thank you for holding the hearing. A busy morning, several things going on, so I apologize for my absence through part of this. If there is a question I ask that has already been asked, I ask that you be indulgent and not point that out to me.

On the issue of value-based services and pay-for-performance, I mean, Dr. Terry, I just have to tell you, there was never a morning when I drove to work in my OB/Gyn practice in Louisville, Texas, where I thought to myself, boy, I really hope I can be average today. You go to do your best work every single day. That is why you show up. That is why you are there for your patients, and I am a little troubled as is Dr. Terry about the fact that we are talking about a system that basically revolves around reimbursement and not so much the deliverable to the patient which, after all, at the end of the day is where we should be concerned.

But the concept has been discussed about having a dual system. Dr. Terry, do I understand you correctly that you would see perhaps value in running both systems simultaneously for a while after October 1st?

Dr. {Terry.} I am not an expert on that but the value is that it is a way to transition. It is a way to let doctors get that year of experience and learn how to do the coding so that they don't--when we turn the switch and they are not ready to do it that their income doesn't go to zero, so that is the value. Now, whether that is the way to do it or not, there may be other ways to do it.

Mr. {Burgess.} Well, it is interesting that you bring that up, because if you go to the CMS website, and I don't spend a lot of time but when I do go, I do go to the Frequently Asked Questions section and there is an item that says dual coding, does my practice need to use both code sets during the transition, and the answer is, practice management systems must be able to accommodate both ICD-9 and ICD-10 codes until all claims and other transactions for services prior to the compliance date have been processed and completed. Well, that is CMS jargon for ``we are not giving you a date.'' So, you know, under their own information on the website, maybe the problem is solved.

You know, you go to other areas on their website and you try to click on the video for how you do this in your own

office, and you are taken to an outside website that you need a username and a password, so you develop a username and a password, you click on it again, and the site is broken. So I mean, there are some real obstacles that you as a practicing physician when you try to do your due diligence and make sure everything is going to go smoothly, there are some obstacles put in your way.

Ms. Matus, your provocative statement to us, and I would love to go--but the chairman has already done it so I won't put the committee through it again, but pull the plug or pull the trigger. I mean, I would just love to go down the line and say trigger or plug, but I think I know what your answers are.

But even at--and I do want to say, your CEO came to talk to one of our roundtables and provided one of the most refreshing views of ways to go forward with things that I have ever heard, so a lot of respect and affection for your CEO at athenahealth, but even on your own website, the Frequently Asked Questions on the athenahealth website, number 7, ``How can the transition to ICD-10 impact my cash flow.'' The answer here is instructive. It says ``CMS

estimates that in the early stages of implementation, denial rates will rise by 100 to 200 percent and the days in accounts receivable will grow by 20 to 40 percent.'' Those are pretty significant figures, and I will just tell you from having run a small practice that you extend my days in AR by 20 to 40 percent and I am probably having to go downtown and ask my friendly banker for a short-term loan at a high percentage interest rate in order to keep my practice afloat. Is that a fair concern of the practicing physician out there?

Ms. {Matus.} I think I am going to add on what Ms. Bocchino said. It depends on what software provider you use. As I mentioned, we do guarantee ICD-10 performance, and part of the reason that we can do that is, we have one completely Internet-based system. So if we, for example, have a claim rejected for one provider, we can go out overnight and make sure that any other claims that are in queue that look similar to that are changed so that they will go through appropriately the next day. So I think, you know, again, it depends on what system you are using and how you are formatted, but there are ways to make this easy to do, and when you think about ultimately--when you heard John, we are

so focused on building the health care Internet, and to be able to do something like that, you need one language. If you think about how we live our lives today, we have one system for financial information, we have one--you know, all our information, all our music is on our phones yet our health care--I have lived in six States, 10 years in the great State of Texas, my health care information is scattered to the winds. So this is really important I think long term for foundationally building a health care system that is integrated.

Mr. {Burgess.} Right, but for those practices that did not have the foresight and intuition to align themselves with your organization--

Ms. {Matus.} There is still time.

Mr. {Burgess.} --they may be in difficulty.

Mr. Chairman, I do want to submit for the record a series of questions by Daniel Chambers, who is the Executive Director of Key Whitman Eye Center in Pete Sessions' district back in Texas, and I just want to point out one of the things that he says there is that physician offices may need to be prepared to go out and cover this delay in accounts

receivable for an extended period of time, and under existing tax law, we are in our practices are not allowed to carry over money in our practices or it is taxed and then we are going to pay taxes on it twice. So this is an untenable situation that a lot of practices find themselves in.

Mr. Chairman, I thank you for the indulgence. I do want to submit this for the record.

Mr. {Pitts.} Without objection, so ordered.

[The information follows:]

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Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentleman from California, Mr. Cardenas, 5 minutes for questions.

Mr. {Cardenas.} Thank you very much, Mr. Chairman.

I would like to thank all the witnesses for apprising us of the perspective that you bring and thank you for representing all the constituency interests that are so important to the health care of all of our constituents throughout the country. Thank you very much.

My first question is to Mr. Averill. I understand that there are concerns that increased number of codes may be a burden for physicians, and I am glad you testified on some of those reasons earlier regarding the switch to ICD-10 and how it would in fact be an excessive burden for some practitioners. You recommended specifically that no individual would need to know all the codes obviously, just like was mentioned smartphones. This thing seems to be smarter than me. There are things that thing does that I don't even know where to start.

I would imagine that with today's technology looking up

codes by doing a word search, for example, would be very simple and wouldn't hinge much on how many codes are available, again not having to know everything but just being able to utilize it accurately and effectively is what I think every practical system is expected to do.

I have a question. Would it be--would I be right to assume that modern technology makes more comprehensive coding systems like ICD-10 manageable?

Mr. {Averill.} Yes, they do, and since the iPhone has gotten quite a bit of visibility today, there is an app for I-10. It is a free app, and you can look up an iden code. If you wanted to really splurge, there is one for $1.99 that will give you a few bells and whistles on your iPhone to look up a code, and if you take that technology, in a few seconds you could look up almost any I-10 code.

Mr. {Cardenas.} Okay. So the technology of today makes it much less burdensome than the implementation of years past, correct?

Mr. {Averill.} Correct.

Mr. {Cardenas.} Mr. Chairman, for the record, before I run out of time, I would ask to submit, the California

Hospital Association asked me to submit a letter to the hearing record that states they are ready for the announced October 1st, 2015, ICD-10 compliance date and urges Congress to avoid any further delays, and I would like to submit that letter for the record, Mr. Chairman.

Mr. {Pitts.} Without objection, so ordered.

[The information follows:]

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Mr. {Cardenas.} Thank you so much.

Carmella Bocchino, did I say your name right? Thank you. I have heard the argument that given that the World Health Organization will be implementing ICD-11 in 2017, the United States should just wait to implement that coding system. I also understand that there is an argument that implementing ICD-10 makes it easier to eventually implement ICD-11 down the road. My question is, would skipping straight to ICD-11 be counterproductive, or what is your opinion on that?

Ms. {Bocchino.} Our opinion is no, it would be counterproductive in that--

Mr. {Cardenas.} How so?

Ms. {Bocchino.} ICD-10 builds off of ICD-9, and there has been a lot of resources and training and effort gone into many, many people in the health care system, not just payers, to get us to ICD-10, and you end up penalizing them for all the resources that they put forward already if you are now going to make the jump and continue to use what I think is an antiquated system in ICD-9.

Mr. {Cardenas.} One of the arguments again, Ms. Bocchino, one of the arguments in any change is come on, we are looking at this with a broad brush. It doesn't necessarily help the individual constituent or the individual patient in this case, but one of the things that I believe that this system makes sense and the fact that the whole world or at least most of the world seems to want to comply and is doing what they can to do so. I think the United States should follow suit.

Doesn't it, at the end of the day, come down to the individual knowing more about what diseases are going on and going around now that the world is getting smaller every day?

Ms. {Bocchino.} Absolutely.

Mr. {Cardenas.} At the end of the day, doesn't it directly affect the individual patient?

Ms. {Bocchino.} It does. It affects the individual patient both in the sense of us knowing a lot more about complication rates, about a lot of the research that actually Dr. Hughes raised up, which is going to drive better patient care and engage patients to better take care of themselves.

Mr. {Cardenas.} Isn't it today more than ever doctors

communicate with each other telephonically, electronically? My understanding, I just had somebody--I helped somebody put somebody in touch with a doctor who lives in northern California, the patient was in my district, and lo and behold, within 24 hours that specialist was looking electronically at some information so that he could give that second opinion where that patient was in the hospital, couldn't physically go see that doctor, but yet again, my point is that communication, that is happening more and more today, and that is a good thing, right?

Ms. {Bocchino.} It is, and it is happening a lot more in rural areas where we don't have a lot of specialization and you need exactly that kind of connectivity.

Mr. {Cardenas.} Thank you very much, Mr. Chairman. I exceeded my time. Thank you.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. {Griffith.} Thank you, Mr. Chairman, and I appreciate that very much. I appreciate the witnesses being here today.

Dr. Terry, if you could help me out on this, I know we apparently got smartphones and all kinds of computer programs that will help you with the ICD-10, but they also come out in book form, do they not, the ICD-9 and the ICD-10? And my understanding is, the ICD-9 is about one volume about yea thick. Is that right? If you can answer for the record?

Dr. {Terry.} Yeah, about 2 or 3 inches.

Mr. {Griffith.} And that the ICD-10 would be about four of those same size books. Is that about right?

Dr. {Terry.} I have not seen it but it makes sense.

Mr. {Griffith.} All right. And you indicated earlier that the rest of the world is using 20,000 codes but that we are about to use 80,000 codes, but then I heard testimony that the World Health Organization is coming out with an ICD-11. Is most of the world using the ICD-10 already or is that just aspirational?

Dr. {Terry.} Yes, the rest of the world is using ICD-10, but it is like you are comparing apples and oranges. The rest of the world is using less than 20,000 codes and they don't use it for billing, they don't use it in the outpatient setting. But you are saying oh, we have to keep up with the

rest of the world but we are doing it totally different.

Mr. {Griffith.} Okay. So if we do it the rest of the world did it, then you would be okay with it, or you could at least figure it out. Is that a fair statement?

Dr. {Terry.} Yes, sir.

Mr. {Griffith.} And you said something about how many codes there were for diabetes, and I failed to write that down. How many different codes are there for diabetes?

Dr. {Terry.} Two hundred and fifty.

Mr. {Griffith.} Two hundred and fifty codes. I guess my problem with the ICD-10 and this whole concept, and it comes down to part of what you are saying. It would seem to me to make sense that you could do a dual system. Now, ultimately, you want to get everybody on ICD-10. I get that. But if you submitted for a period of years ICD-9 and ICD-10 and if you got either one of them right, you got paid, then that would probably alleviate your fear and concern. Is that correct?

Dr. {Terry.} My fear is just being able to take care of the patient and not being put of business because I code wrong. That is my fear, and how you can fix that? Like I

said, there are several ways to do it.

Mr. {Griffith.} And do you know what the projections are on the numbers of the shortage of doctors that we are anticipating having in this country?

Dr. {Terry.} I don't know numbers but it is definite. I mean, there are fewer people wanting to go into the practice of medicine because of the financial aspects, and it is just--

Mr. {Griffith.} And lots of paperwork and dealing with lots of computers instead of seeing patients. Is that right?

Dr. {Terry.} You are talking about computers and statistics, but one thing hasn't changed, and that is the care of the patient, the sitting down and listening and examining and talking. Computers can't do that. And I don't have time to do that anymore. I am sitting in my office with my back to the patient typing on my computer trying to take care of my patient, and if you have a 15-minute office visit, that is getting whittled down by 50 percent now, and it is not all ICD-10. It is Meaningful Use, electronic medical records. It is trying to learn how to deal with this, but ICD-10 is going to pile on it.

Mr. {Griffith.} And as a result of that, it wouldn't surprise you that either last year or the year before that, I sat down with a doctor in one of my rural communities that I represent and his number one complaint was ICD-10, and he said look, I am getting old, I am not a dinosaur but I am getting old, or older, and I love serving this community but I don't know if I am going to continue to practice.

So you would anticipate that pushing with a drop-dead date, as Dr. Burgess pointed you earlier, the dual coding is only going to happen up to a certain date, not allowing for things to go forward after that. You think like him that there would be a lot of other doctors that may decide that it is just time to go ahead and retire and enjoy their house at the lake?

Dr. {Terry.} There is no question. I already have a doctor in Mobile that has already quit because of the thread of ICD-10 plus he didn't want to have to take his boards a fifth time, and there are a lot of people--you know, I am 60, 61, you know, there are a lot of people between age 61 and 65, they are not going to do it. Now, how do you measure that? I am just telling you it is going to happen.

Mr. {Griffith.} So what we are going to see is that my allergist, who served my family for five generations and who didn't stop practicing until 1992, and even though his body was getting weaker all the time, his eyes flashed and he always knew what was going on, you are indicating to me that we are not going to have those doctors continue into practice as long and that that is going to create a problem in our rural communities, notwithstanding the fact that some of the younger doctors like Dr. Burke will figure it out, but it is going to create a shortage of doctors, particularly in the rural areas. Am I correct that that is part of what you are saying here today?

Dr. {Terry.} Yes, sir, but it doesn't have to be that way if we can change the ways being implemented. It doesn't have to be that way.

Mr. {Griffith.} Well, I appreciate you being here very much. I appreciate everybody else, and I understand for big practices and big cities, all of this is easy, but it is not so in the rural areas where we are already having health care shortages.

Thank you. I yield back.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes Mr. Long from Missouri 5 minutes for questions.

Mr. {Long.} Thank you, Mr. Chairman, and thank you all for being here today.

When I was elected in 2010, and we came up for orientation that next week, there was 96 new Congressmen out of 435, and we were all excited, and they gave us our little briefcase with things in it, documents, everything we need, and they gave me a BlackBerry, and I said what is that. They said everyone gets a BlackBerry. I said I don't get a BlackBerry. They said why not. I said I have never had one, I don't know how to use one. I get an iPhone. No, no, no, we don't get iPhones, you get the government issue, you get a BlackBerry. I said I don't want it, I can't use a BlackBerry, I don't want to relearn a BlackBerry. So I was the first Congressman that changed the policy here, so I hold the record. I was a 55-year-old freshman at that time. I was a 55-year-old trendsetter. So I got my government-issued iPhone and now they give them to everybody. I know it is a little off the subject but that is what all the discussion was on iPhones or BlackBerrys here this morning.

1875 And Dr. Terry, you do the best impersonation I have ever
1876 seen of my doctor in Springfield, Missouri. I should say my
1877 former doctor, because when Obamacare first passed, I went to
1878 see him, and you remind me of him because I told him, I said
1879 if you don't settle down, I am going to have to check your
1880 blood pressure. He turned around to the computer and he was
1881 working just like you imitated a minute ago, and he said I
1882 have got to do all this paperwork now. He said I have got 10
1883 hours a week just on new things. He said it used to be I
1884 would send you out of here and now you have to sit there and
1885 answer these questions for me, and he quit about 6 months
1886 after that, and he was in the same age bracket as you and I,
1887 and he had several good years left in him. So I know that
1888 this is very disconcerting for a lot of doctors.
1889 And for my friend from my State of Missouri, and you are
1890 from where in Missouri?
1891 Dr. {Burke.} Fredericktown.
1892 Mr. {Long.} Fredericktown. My mom's people originally
1893 came from Fredericktown, so we have got a little in common
1894 there.
1895 You said--I don't guess you said it, but there are

supposed to be significant public health benefits to the greater coding and reporting under ICD-10. Will you kind of discuss some of those benefits?

Dr. {Burke.} I mean, you know, for instance, if, you know, someone comes in with COPD, or emphysema, you would put the code in, and it can talk about an acute exacerbation or chronic COPD, unspecified. So it gives us a clearer picture of what is going on with the patient.

Mr. {Long.} Okay. And I have heard of both of those, but the ICD-10 diagnosis codes have been readily mocked for their more obscure codes. For example, there is a code--I don't know if you run into this--but in our neck of the words down in Missouri, you might need this one: bitten by a pig, initial encounter. And walked into lamppost, subsequent encounter.

Mr. {Griffith.} What about a subsequent encounter with the pig?

Mr. {Long.} Maybe that is why he ran into the lamppost. A pig bit him, and he ran into the lamppost. Isn't this overwhelming for small solo practices in rural America like your represent, not that you have a sole practice, but I

mean, you are out there in a town of 4,000 people.

Dr. {Burke.} Yeah, true. I don't think it's overwhelming. I think it is easier to find a diagnosis because you have a lot more choices for the diagnosis.

Mr. {Long.} I would say you do if you have got ``bitten by a pig.''

Dr. {Burke.} So, you know, I think it is--I just don't think it is overwhelming, not at all, not in the slightest bit. You know, for the scope of my practice, which is internal medicine, and actually our software is the one that helps us out because, for instance, if someone comes in with a complaint and there is an ICD-9 code in the chart, we can click on the ICD-9 code and then a bunch of different ICD-10 codes can show up, and we can go through the list and pick one which is more specific.

Mr. {Long.} Okay. You said in your opening remarks that it was--I am paraphrasing but kind of like a light switch. You switch one day from 9 to 10 seamless, no problem whatsoever. Dr. Terry in his answer to a question earlier I believe said that it would take $5,000 in training to get somebody up to speed. Did you have to undergo any special

training or spend any money or go off somewhere to learn this, or--

Dr. {Burke.} No, I didn't, and neither did the nurse practitioners, so no one in our office did.

Mr. {Long.} Okay. And Ms. Bocchino, health care communities has had years to plan for ICD-10 including several delays. Have the insurers used this time to prepare?

Ms. {Bocchino.} Absolutely, and they have worked with the providers in their network to do end-to-end testing in providers of all size, so they have done a lot of outreach, even to the smaller providers. I will be honest that it is difficult sometimes to get the smaller providers engaged, but in part that is because many providers believe that we are going to keep moving the date, and until we are firm on a particular date that they know this is coming, I don't think we are going to get some of them engaged. I think it is very important to send a strong message.

Mr. {Long.} Okay. Thank you. I downloaded a couple of apps here on my iPhone on ICD-10 after we were advised earlier, but you said a dollar. Now, the first one that came up was $4.99 but I did find some free ones, so I have got two

apps. Now I can go study and see what is in there besides first encounter bitten by a pig, and I yield back.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the Ranking Member of the full committee, Mr. Pallone, 5 minutes for questions.

Mr. {Pallone.} Thank you, Mr. Chairman. I feel like old times up here today. This is nice. And I apologize. I was at one of the other subcommittees earlier so this is why I missed your testimony.

But I wanted to ask Ms. Bowman, or Mrs. Bowman, I guess, you mentioned in your testimony that the demand for high-quality data is increasing due to health care initiatives that aim to improve quality and patient safety while decreasing cost. Can you explain how ICD-10 will interact with the electronic health records Meaningful Use incentive program, and what about other delivery system reform efforts?

Ms. {Bowman.} Sure. The ICD-10 codes in addition to being used directly for reimbursement like we have heard a lot about today is also used for a lot of administrative data reporting purposes where aggregation of data is important. So it helps to provide data for all these other programs like

value-based purchasing, accountable care organizations to show the severity levels of different conditions so that you can link that to outcomes to best practices, to different treatment options and see really what works, what doesn't work, what is the most cost-effective form of treatment. If you have better information about what is really going on with the patient and the level of severity of a particular illness, not just a generic description for that illness, you can fine-tune that information a lot better and really drill down to what works and what doesn't work.

Mr. {Pallone.} Okay. Now, you also mentioned that the updated ICD-10 codes would help with reimbursement. Would you want to explain how it would ensure more accurate and fair reimbursement or more accurate codes would reduce providers' or payers' administrative burden, for example, in clarifying diagnosis and procedures?

Ms. {Bowman.} Sure. Because of the increased specificity, you can drill down to different forms for the same reason. They kind of give you better information on the different costs related to particular diagnoses and procedures. A great procedure example that I think Rich

might have used in his testimony but I heard it before is, suture of artery. So we have a single code that is a procedure example, and it doesn't matter whether it is the aorta or an artery in your little finger. It is the same code in ICD-9, and obviously there is enormous differences in complications and the cost of repairing the aorta versus other types of arteries and yet we are lumping it all into the same code. So by having better specificity on the procedure side, a lot of it has to do with approaches, anatomic sites on both the diagnosis and the procedure side. We can really be able to fine-tune information about the cost of treatment, which then links to the appropriate reimbursement for that treatment.

Mr. {Pallone.} And you mentioned about the cost and danger of continuing to use the ICD-9 codes. Who are those costs affecting?

Ms. {Bowman.} These costs are affecting everyone, our entire health care system, providers, payers, the patients because right now because we don't have that specific information and ICD-9 is just deteriorating and failing more year after year that we use it. We are getting less and less

information for each clinical encounter, and basically reimbursement, analyzing quality of care based on that data are just wild guesses at this point because there are so many disparate conditions or procedures that are lumped into a single code, and in some cases some of the testifiers had talked about differences in ICD-10. Some of those differences have to do with just changes in clinical knowledge since ICD-9 was developed. So some conditions are actually categorized somewhat differently. I believe there is even some medical conditions that are not categorized as cancer in ICD-9 but are categorized as cancer in ICD-10 because of changes in medical knowledge. So we are losing a lot of that information by continuing to use ICD-9.

Mr. {Pallone.} Okay. And then lastly, some providers argue that ICD-10 is unfair because it was developed by bureaucrats that have never practiced medicine, but you mentioned in your testimony that 95 percent of the requests for new codes in the past few years came from physician organizations. Can you just talk a little bit about how i10 was developed and who was involved?

Ms. {Bowman.} Sure, and that has been one of the

biggest myths, I think, of ICD-10 is that it was developed in a back closet somewhere by bureaucrats. I have actually been involved in the development of ICD-10 since the 1990s now, and it is still being updated and maintained every year, and all of the content of the original ICD-10 that WHO uses, the clinical modification that the United States is trying to implement, all of it was contributed to greatly by the house of medicine who participated in the development, asked for that clinical data and continue today to come to public meetings that are hosted by the CMS and CDC to discuss proposals for new codes, and it is a completely public process. Anyone can submit a request for a new code. It is discussed in a public meeting. There are opportunities for public comments at the meeting or in writing afterwards, and CMS and CDC take all of those comments into consideration in making a final decision about adding new codes.

Mr. {Pallone.} Thank you.

Mr. {Pitts.} The chair thanks the gentleman and now recognizes the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. {Bucshon.} Thank you very much, Mr. Chairman.

I was a practicing cardiovascular surgeon for 15 years, so at the end of the day this is about money. This is going to cost physician practices initially, and I agree with Dr. Terry on the implementation. It is pretty clear that we are going to move forward on ICD-10, and we should, but I do have substantial concerns about the implementation and the short-term impact on physician practices because that will happen, and I am disappointed that some of the experts in non-health care fields that don't practice medicine are here today denying that will happen. That is very disappointing.

Ms. Bowman, have you ever practiced medicine? Have you ever had to bill a patient?

Ms. {Bowman.} No, I have not practiced medicine.

Mr. {Bucshon.} Let me tell you what is going to happen, and I am going to--because you--and again, ICD-10 is going to happen. It needs an implementation plan. I agree with that. I don't think we have a disagreement there, but that said, here is what happens when you are a surgeon. You will do surgery, and it will be much more difficult for you or your people to find a code that matches what you write on your operative report. You know why? Because you are going to be

in the operating room and you are going to dictate what you actually did. You are not going to look through an ICD code book and make sure it matches. And so when the insurance company gets the code and they get the operative report, they are not going to match, and it is going to come back to your office and you are going to have to try to figure out, and then what do you do? Do you modify part of the official hospital record and say no, that is not--I had to change it to match a code? You could do that. But it will not make it more easy to get the correct code. From a practicing physician, my opinion, that is just false. That won't happen. So I am concerned about that.

Dr. Burke, is your practice independent or are you part of a larger health care system?

Dr. {Burke.} There are two physicians and three nurse practitioners, and I am--

Mr. {Bucshon.} So you are not part of a larger conglomerate that owns your practice?

Dr. {Burke.} No, privately owned.

Mr. {Bucshon.} Okay. That is good because it is a rarity that that is happening today, and the reason is, is

because the cost to run an individual medical practice is very difficult. I was in a 15-surgeon, 16 cardiology practice. We had to sell to the hospital. We couldn't afford to stay independent anymore.

But I was interested in your cost statement, that it didn't cost anything. What are your annual IT costs? What is your--how much do you pay a month for your IT service?

Dr. {Burke.} I would have to talk to the office manager about that.

Mr. {Bucshon.} My point is, you made a statement that said the cost is zero, and that is just false because you are making monthly or annual payments to your IT and this type of implementation is included in that cost.

We put an EMR in in 2005 in my practice. It cost us $3 million up front, $60,000 to $80,000 a year just to maintain the current software. This is extremely expensive for medical practices. It may not be that, you know, oh, converting from ICD one day to the next cost you anything, but it is costly, and I think that that is something I want to clear up because I think that is just not accurate.

Ms. Matus, do you know what percentage of the health

care costs are related to physician services?

Ms. {Matus.} I don't know specifically.

Mr. {Bucshon.} People estimate about 10 to 15 percent. Where is the rest of the cost to the American people for health care?

Ms. {Matus.} I would imagine it is in administrative.

Mr. {Bucshon.} Yeah, about 25 percent is in administrative and then, you know, there is hospital expenses and others, right?

So, you know, the reality is, is that trying to continue to save Medicare or save our system by cutting reimbursement to providers is a failed strategy, and this is what this is about because what is going to happen is, is you are going to have physicians who are not going to be able to code this properly at all age groups except if they work for you, which it is great that you have a great system, but the individual physician out there is not going to be able to do this correctly, and their AR is going to go dramatically up and they are going to get denied, and it is not just for Medicare. It is going to be from every other private insurance company out there.

So I would encourage all of us who are involved in health care including on the administrative side to really look closely at our implementation plan and make sure that we can implement ICD-10, which we need to, in a way that does not really cause dramatic problems with our health care system.

My practice, you know, we could afford to have a line of credit of $1 million. With this kind of thing, we could front it for a few months. Many practices can't.

And lastly, Dr. Hughes, the example that you gave of a 74-year-old with a vascular injury, I did vascular surgery. Other than for your research and for statistics, how does that impact that patient's medical care? Because given your example, it has no impact on the outcome of that patient, not a single--nothing that--

Dr. {Hughes.} I am sorry if I gave you the impression that that individual patient would be affected because you are absolutely right, it is not going to have any impact.

Mr. {Bucshon.} It won't make any difference.

Dr. {Hughes.} It won't make any difference to that individual patient. The point I was trying to make is that

the accumulation of data is useful, and I disagree with Dr. Terry. I do believe that it is possible to look at data in a scientifically sound method and to derive useful information from it. We have got lots of information from the National Surgical Quality Improvement Program, for example, but you are absolutely right. It is not going to make any difference to--

Mr. {Bucshon.} I just wanted to clear that up that in the short run, implementation of ICD-10--and thanks for your indulgence for a second, Mr. Chairman--will not have a direct impact on the individual patient care. It may in the long run based on your research, which I agree.

Thank you, Mr. Chairman. I yield back.

Mr. {Pitts.} The chair thanks the gentleman and now recognize the gentleman from New York, Mr. Collins, 5 minutes for questions.

Mr. {Collins.} Thank you, Mr. Chairman. Sorry I was somewhat late. I was actually here on time, but I serve on Oversight. We were just ending a hearing on mental health, which I wanted to stay until it was over. So I missed most of the testimony although I did review the information, and

just to set the stage, I am a supporter of ICD-10. I am a supporter of getting it implemented sooner than later. It has been on the agenda a long time. This isn't something that should be new to anyone. Most countries in the world are doing it. I certainly have a lot of physician friends, and I understand there is a cost of implementing anything new. You know, we can, I suppose, debate the benefits.

I am also a data guy. In my office I actually do have a sign that says ``In God we trust. All others bring data.'' And I know that with data, whether it is analysis or other things we can do with it, while it may not be a positive for that patient today, at some point in time being able to deep-dive data, especially with health care costs going up in this country as they are, someone of my son's young age will be able to really use that data. He is very adept at that.

So I guess my question is--and feel free--I am sorry, I don't know who would be best at answering some of these, but I would see the data collection as a very major part of why we are doing it and maybe perhaps the other piece--I don't know if this came out--some identification of potential, I will use the word ``fraud.'' You know, the more data we

have, the more specific someone has to be, and if someone could comment too, I would assume a lot of the coding will be done by the office staff. I mean, a dermatologist is going to be rocking and rolling. Her staff knows that I would think a lot of the coding would be coming from that. Is that a good assumption or bad, and could anyone speak to where this data would be helpful in the medical field going down the road?

Ms. {Bowman.} Yes, you are absolutely right. The data is very useful and helpful, and the fraud arena is one example, and the research that Dr. Hughes mentioned, yes, in most cases it is not necessarily going to help that patient today but the accumulation of data and knowledge about medical care will ultimately lead to better care for patients in the future.

There are some scenarios where it could help the individual patient today such as in the area of disease management. I know of some facilities now that are using the better diagnosis codes in their internal systems for disease management programs, particularly in the area of diabetes and asthma, because the clinical classification of asthma in ICD-

10 is totally different than ICD-9 and is much more aligned to the way people are currently managing asthma, so I know of some facilities that are using the data that way.

With respect to the coding, obviously in hospitals almost all of the coding is done by professional coders who do the coding. In large practices, it usually is designated staff, and so there is a cost to the practice obviously, even in those situations of having the staff trained, and then in some smaller practices such as the Beyer Medical Group that is here today, it might be physicians who are actually doing their own coding but in a lot of scenarios it is usually a trained staff person.

Mr. {Collins.} So this has been implemented, am I correct, in other countries?

Ms. {Bowman.} Yes.

Mr. {Collins.} What have we learned--and we have only got a minute or so--the benefits of this has been evidenced by other countries having already implemented it?

Ms. {Bowman.} Well, Dr. Terry, I think it was, in his comments is absolutely correct. Other countries are not using it in the same way that we use it, and that is kind of

a catch-22. That also makes it more complicated for us to implement it because of the fact that we do use it in our reimbursement system. So they didn't have some of the challenges and the costs and the issues that we are facing.

There was a comment earlier about not being comparable globally. However, we have a treaty with the World Health Organization for ICD. The modifications individual countries can make to ICD have to be beyond a certain character level in order to be able to maintain global comparability, and as I had mentioned in my testimony, almost half, actually 46 percent, of the additional codes in our modification are due to laterality, which is not in the international system, primarily because although they are actually oddly enough looking at that in the area of ICD-11. They are actually looking at what we did in our clinical modification as they work on ICD-11.

So there is comparability with the rest of the world because a lot of the detail, it has to do with ways we use the codes in our country that just aren't applicable to the rest of the world, the laterality and also there was significant request for--I know there was jokes about the

subsequent encounter and initial encounter but those kinds of things, which are all in the seventh character, are where some of those additional codes come, and it is actually intended to improve our data from ICD-9, which right now if you have a follow-up encounter, it goes into a very generic aftercare code, which has been a big complaint for 30 years in the ICD-9 system that I can't tell that the reason I am seeing the patient was because they are being followed up for a fracture of the humerus. All I know is, it is orthopedic aftercare or a follow-up examination for who knows what.

So these encounter seventh characters were specifically created to solve that problem in ICD-10 so that it is an added digit to say you still use the original injury code but you know from this particular character that it is a follow-up visit and not the initial acute injury.

Mr. {Collins.} Thank you, Mr. Chairman. I yield back.

Mr. {Pitts.} Thank you. The chair now recognizes the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. {Ellmers.} Thank you, Mr. Chairman, and thank you to our panel for being here, and I too apologize for coming

in late, so if any of the questions that I ask have already been answered, again, I just apologize. I am trying to get to the bottom of this issue.

First, I would just like to say I am a nurse myself. I practiced before coming to Congress as a nurse for over 21 years. My husband is a practicing general surgeon, and I will just have to say that my husband's opinion of moving towards ICD-10 is very much like Dr. Bucshon and Dr. Terry, although we know that this needs to be implemented at some point. I believe the frustration that exists within our medical community, especially our private practitioners, is that there is so much on top of them right now dealing with so much that now this is just one more issue that they are going to be forced to deal with. Many of our physicians and hospitals alike are still trying to meet stage II of Meaningful Use, and here we have yet another situation where we are going to have to deal with this.

So I want to get to the bottom of this. I want to see ICD-10 move forward but obviously we have to address the issues as they are in the realistic world rather than the theoretical world where this would be a wonderful thing as

implemented. We just have to get there and apply it to the realistic world of health care and medicine as it is today.

So one of the big issues that we here continuously is, again, the cost, and the cost--you know, we know that our hospitals have invested millions in preparing for ICD-10, and I believe that that needs to be respected and we need to consider that for our physician practices, especially--and I know, Dr. Burke, you are practicing in a rural area--especially for our rural physicians and some of our smaller practices.

Dr. Averill, what can be utilized? Is there a cost incentive for physicians to embrace ICD-10 that you are aware of?

Mr. {Averill.} Well, first of all, let me say on the cost--there was just a recent study that was just released in which PAHCOM, which is the office managers for small physicians, surveyed their membership, and they asked the question, ``What has been the expenditures getting ready for I-10 plus the expenditures remaining to be expended?'' so the results of that survey essentially said for a small physician practice where that was defined as six or less

direct caregivers, the average expenditures to date plus anticipated expenditures was roughly $8,000.

Mrs. {Ellmers.} Okay.

Mr. {Averill.} And then there were two other studies that were recently published that actually came in with lower numbers. The market has really responded in terms of making the transition much easier and much more cost-effective. As I mentioned before, there is lots of free software out there. There is lots of free training material and so on. So I think in terms of what is available, the transition can be made. I think the biggest problem is the uncertainty, the uncertainty of should we invest the time, should we move forward when there is an uncertain date. You know, it is a tough competition for how you are going to spend your dollars. Do you want to spend it on ICD-10 preparation when it may not ever occur? The most important thing is to say will it occur and when, and for once and for all, get that out there and let the industry move forward.

Mrs. {Ellmers.} So again, just to clarify again from the cost standpoint, there is software available that physician offices can take part in. There are cost issues

that can be addressed. And again, that is your position as far as addressing the cost issue for physicians and training?

Mr. {Averill.} Yes. The market has responded and those services are readily available at a very low cost, and it is a decision on the part of the individual physician office to take advantage of that.

Mrs. {Ellmers.} Dr. Terry, would you concur with Mr. Averill on that?

Dr. {Terry.} I thin, his comments represent the minority. I know plenty of physician practices who have paid a lot of money to--I mean, if you are stuck with an electronic medical records and you don't have a contract that says they are going to update it, you are stuck because you can't change it. They control our practices now that we got that electronic medical records. I have to do what the company tells me to do, and I can't bargain. I mean, it costs. I mean, this is--and I respect their study but their own people kind of did the study. I mean, are there conflict of interest in it? Are there--how is it done? Has it been repeated? But I respect what they did but I just think it is crazy to say there is zero cost or $5,000 cost. It is more

than that.

But, you know, cost is not what I am--it is not an issue to me. I don't care about that. The thing is the implementation and doctors not being able to stay in practice and taking care of their patients. I don't really care about the cost.

Ms. {Ellmers.} No, and Dr. Terry, I agree. That has been one of the issues that I think we all have heard, and those of us who have been in the health care world, we want to give the best care we possibly can to our patients, and when we have been whittled down to a few moments in the exam room with them and really understanding their issues, it really doesn't matter how much information we can gather. We are not gathering it because we are basically on a time constraint and there is much that will be missed.

So with that, again, I just want to say thank you, Mr. Chairman, and thank you to our panel. This is a very, very important issue, and I just hope that we can all come together to work on a solution moving forward so that we can continue to provide great health care to every American. So thank you.

Mr. {Pitts.} The chair thanks the gentlelady. That concludes this round of questioning. We will go to one follow-up per side, and I will recognize myself for that purpose.

Dr. Hughes, when a patient's health care requires multiple providers, which coding system will allow the most comprehensive detail informations sharing to ensure each has the best information to care for that patient, ICD-9 or ICD-10, and please elaborate.

Dr. {Hughes.} ICD-10 provides more information. Let me reiterate that for the patient in front of you or in front of those several providers, it is not going to make a whole lot of difference. Hopefully the several physicians that are caring for this one patient are sharing information and they should not need a computerized data system in order to learn what their colleagues are doing or have done. So for the one patient, I don't think it makes a whole lot of difference but the difference comes when you are talking about patterns of use, when you are talking about how many doctors in this area use an assistant surgeon versus another area where you could be talking about some pretty considerable differences in cost

because you get two surgeon bills instead of one, you know, the involvement, if there is more than one procedure, then yes, you want to have detail, but that is going to be billed anyway.

I think it is only when we look at the patterns and see how the technologies are evolving that that is where it is going to be really valuable.

Mr. {Pitts.} Does anyone else want to comment on that?

Dr. {Terry.} I will just say that I don't treat my patient based on a code, and all of these electronic medical records, you think my office talks to the doctors in California through a computer? No. They don't talk to each other. That code only goes to CMS and the insurance companies to do whatever they want to do with it. One is to deny payment to us if we don't get it right. I don't take care of patients based on a code. That is just something else I have to do.

Mr. {Pitts.} Anyone else?

Mr. {Averill.} I will just make one observation in follow-up to that, that much of this additional specificity has been requested by the medical community. For example,

the urologists that have been coming to the coordination maintenance committees over the last 3 years have asked for 200 new codes to be added to ICD-10, arguing that there is not enough--as much specificity as there is in I-10, the urologist community is asking for 200 additional diagnosis codes. And so we are kind of in a dilemma as an industry. There is continual pressure coming from the medical community for more and more precise information to be used for everything that we have talked about today, and at the same time, there is great reluctance to say that we are willing to collect it and submit it. So I just find it very interesting that the urologists are demanding more and more information and that I-10 becomes further and further expanded.

Mr. {Pitts.} All right. Thank you. The chair now recognizes the Ranking Member, Mr. Pallone, for 5 minutes for questions.

Mr. {Pallone.} Thank you, Mr. Chairman.

I just wanted to ask Dr. Burke, you testified that ICD-10 is a better communications tool. What are some of the critical differences between ICD-9 and 10, and how have the more specific codes helped you in your practice with patient

care?

Mr. {Burke.} Well, as I said, it is a better communication tool, but I would say, for instance, ICD-9 code would be coronary artery disease, but an ICD-10 code could have which vessels involved or which graft is involved if the patient has had surgery. It was easier to communicate that with the patient in describing their clinical condition when you see them.

Mr. {Pallone.} I mean, the concern is the large number of codes but, I mean, your experience in navigating all these codes with more than 100,000, I guess, now, it doesn't matter? I mean, in other words, it is not that much more of a burden?

Dr. {Burke.} No, not at all.

Mr. {Pallone.} Okay. Let me just ask, Mr. Chairman, Mr. Averill because he was out here, you know, just testifying about the cost of another delay. Can you help us understand the effect each time implementation is delayed? What does the delay affect? What types of, you know, training and resources go into preparing for ICD-10 implementation? What is the cost of delay?

Mr. {Averill.} Well, I think it is twofold. One, vendors, CMS, payers have to essentially maintain dual systems. We have to be ready at any point once the final decision is made to go fully forward with ICD-10 or continue to support I-9 and all the various claims adjudication and all the evaluation of quality metrics and so on. We have to have parallel systems. That is a tremendous cost.

Further, the cost of the delay is the uncertainty of it all. We have talked a lot about having people be prepared and be ready, but in a time of tight expenditures and so on, if you are not sure that the date is firm, that is causing many people to postpone doing the final preparation to be ready, and so yet another delay, frankly, if we go to a third delay, I don't believe the industry is going to believe that we will ever move forward, and the transition will become that much more difficult if and when it ever occurs.

So after two delays--and I just want to point out, the original proposed rule on I-10 was 2011. Then based on public comments, it was moved to 2013, and then we have had our two delays that have occurred subsequently.

And so it is the uncertainty of the date that is causing

the major problems out there in the industry to be absolutely at the end of the day prepared for a smooth transition.

Mr. {Pallone.} Thank you. Thank you, Mr. Chairman.

Mr. {Pitts.} Thank you to each of the witnesses. Excellent testimony, very informative, very important.

We will have follow-up questions from members, those who weren't able to attend. We will send those to you in writing. We ask that you please respond promptly.

I remind members that they have 10 business days to submit questions for the record. The members should submit their questions by the close of business on Thursday, February 26th.

So with thanks to our panel, without objection, the subcommittee is adjourned.

[Whereupon, at 12:30 p.m., the Subcommittee was adjourned.]