A Health Data Consulting White Paper

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ICD-10-CM

The Case for Moving Forward

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23 March 2012

THE CASE FOR MOVING FORWARD WITH ICD-10

It would be difficult to ignore some of the recent reaction to the impending implementation of ICD-10-CM coming primarily from the physician side of the industry[1]. This has resulted in a suggestion from the Department of Health and Human Services (HHS) that there may be a delay in implementation to allow more time for physicians to prepare to properly implement this much belated transition to a new system for coding patient health conditions and inpatient procedures. Unlike much of the rest of the world, the United States has consistently resisted the update of a 30 year old classification system. There are many reasons to move towards ICD-10-CM, but there have been a number of statements that might suggest the contrary. This paper will review some of the existing stated reasons for delay, and present a different perspective.

"There are too many codes"

It is true that ICD-10-CM has many more codes than ICD-9-CM. But we have lots of words in the dictionary but that doesn't seem to be a problem for writers. Most providers will only use a small percentage of the codes and most codes are simply extensions of the same concept with some additional information to refine the description of the condition. One third of the codes are exactly the same except for the differentiation of "left" or "right". Though there are over 1800 codes that are related to "fractures of the radius", there are only about 50 unique medical concepts related to those fractures. All of these concepts are important clinically, but because of the combination nature of the codes, there are many repeating patterns resulting in many more codes. ICD-10-CM is much more consistent and better defined and should allow for more effective conversion of good documentation into accurate codes. The number of codes is not really the issue.

"We should wait for ICD-11"

This statement really doesn't make sense for a number of reasons:

- ICD-11 is not slated to be released from the World Health Organization (WHO) until 2015. Historically it has taken us over 20 years to get to the current state, where we "don't have enough time" for implementation. Given any consideration for our historical adoption, it will conservatively be 2035 before ICD-11-CM[2] could be implemented in this country.

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[1] "ICD-10 – Physician Impacts", Advisory Board (Application and Technology Collaborative) Mar 2011

[2] Once ICD-11 is published the Clinical Modification (CM) will still need to be addressed consistent with the US historical modification of this standard.

- ICD-11-CM will be a much greater leap from ICD-9 than from ICD-10-CM. The transition from ICD-10-CM to ICD-11-CM appears to be much less of a paradigm shift. It makes much more sense to move to ICD-10-CM and then incrementally move to ICD-11-CM in the future.
- ICD-11-CM will probably allow much greater clinical integration than ICD-10-CM, but ICD-10-CM is also more clinically relevant that ICD-9-CM.
- ICD-11-CM will require substantially greater documentation requirements than ICD-10-CM and yet it is a challenge to consistently get appropriate documentation in support of ICD-9-CM today. We have a long way to go to improve clinical documentation before we can begin to realize a coding system as advanced as ICD-10-CM, let alone ICD-11-CM.

"ICD-10 is much too complicated"

Coding is complicated. Perhaps more than it should be. For most clinicians it's not about coding, it's about clinical documentation of records to support accurate coding. Professional coders are doing most of the work to learn and apply ICD-10-CM codes and almost unanimously, coders and coding associations are fully in support of ICD-10-CM. Despite the number of codes, the structure, consistency and guidelines in ICD-10-CM is generally felt by coders to be an improvement over what we have today. Coders have extensive resources available to them for educational purposes. New tools to support coding and to help prompt clinicians for proper documentation are continuing to evolve so that finding the correct code should be much simpler as we get closer to implementation.

"ICD-10 creates an unnecessary documentation burden."

The medical concepts that need to be documented to support coding in ICD-10-CM are in almost all instances, important in appropriately assessing and managing patient conditions. It would be difficult for a physician to say that this information was not needed. Documentation of these concepts is just a part of good patient care. It's also not that difficult. Documenting "left" vs. "right" accounts for the only difference in over a third of all of the codes. While there are a lot of codes, there are recurring patterns of the same type of documentation requirements in thousands of codes. None of these requirements should be considered burdensome, or unimportant in the care of the patient.

"We should just go to SNOMED."

While SNOMED is a much more robust coding system for capturing clinical information, it has over 300,000 codes and is a much more complex coding model[3]. Most of the industry does not have any experience in using SNOMED codes historically. Training coders would be substantially greater and coding quality would be at much greater risk. From the perspective of historical data, SNOMED is so different from the ICD-9-CM based data that we have today that it would be very difficult to reconcile. Mixed ICD-9-CM and ICD-10-CM data in historical data sets can at least be normalized at a reasonable categorical level.

"ICD-10 won't help me take care of my patients."

While it is difficult to show how ICD-10-CM will improve the ability of the physician to take care of patient on a case by case basis, there is an opportunity to improve healthcare delivery through enhanced informatics in a way that should allow for more effective, higher quality, evidence based care to be delivered in a way that is affordable and assures patient safety. Physicians need to have broader perspective on their important role in contributing to healthcare information that can support improvement in how care is delivered and assessed in this country. Better information ultimately leads to better care. It's not all about that one visit with one patient. It's bigger than that.

"ICD diagnosis codes are irrelevant to my business."

Many physicians believe that since payment is not directly related to ICD diagnosis codes, that they are irrelevant. These codes however do impact the business and will do so even more in the future.

- These codes factor into processing rules on the payer side that determine coverage, service authorization, referral requirements, appropriateness and other rules that may determine if the claim is paid, pended or denied.
- ICD diagnosis codes factor into measure of quality and may impact pay for performance, tiered payments, withholds or network exclusions.
- As we move forward into more value based payment models outside of the traditional fee for service environment, ICD-10-CM will be an important part going beyond the "What" and beginning to include the "Why" as a part of the payment model.
- As providers begin to take on the risk for the care for populations, intelligence into the nature of their patient population and the cost of management of different diseases will have increasing importance.

3 "SNOMED-CT in an EMR Will Ease Transition to ICD-10 and CAC", Advisory Board (Application and Technology Collaborative) Dec 2010

- Contracting decisions may include case mix and severity adjustments that will be driven by the definition of the health state of the patient.
- Measures of fraud, waste and abuse will utilize information provided by these codes.
- There is little doubt that audits and recovery of payment are on the rise and will continue to increase in the future. Proper coding supported by proper documentation is key to successfully responding to these audits.

"It's unreasonable for administrative bureaucrats to interfere with how I take care of patients."

It is hard to imagine that in a discipline as scientifically driven as healthcare, we view data capture as a burden. The restaurant industry relies on precise data about each customer encounter for operations, marketing, strategic planning and a host of critical business functions to sustain relatively small margins. Contractors often use precise design and customer preference data to plan, budget and bid for work. A physician would not accept a vague description of problems and services rendered by a contractor addressing problems with his house, and would certainly not accept that incorrect data was just for "billing purposes" to enhance payment. Collecting and sharing data about patient conditions and the services that were done to improve or maintain those conditions is a required part of being in the healthcare business. Providers are receiving payment for services rendered. Payers have a responsibility to assure that the care their members receive is effective, safe, high quality and affordable. Reporting incorrect information about what was done and why it was done for the purpose of enhancing payment is fraud.

"There are a bunch of irrelevant codes that make no sense."

There are a number of codes that sound strange and perhaps silly and unnecessary. Codes like "hit by a spacecraft" or "suicide by paint ball" or any number of codes are put up as poster children of the "extravagant" proliferation of ICD-10-CM codes. It is seldom noted however that the codes mentioned above have been part of ICD-9-CM for years. It historically has never seemed to be much of an issue however, since clinicians only use the codes that are appropriate for their purpose. Though codes related to spacecraft might seem silly, for NASA, some of these codes help track important aspects of healthcare in the space program. For them these codes may have meaning, for others, they are just there like other words in the dictionary. For the clinician, "hit by a spacecraft" code will rarely impact them unless they are involved in space medicine.

"More time is needed to implement."

ICD-9 is over 30 years old. ICD-10-CM has been in use for over 20 years. Though we use ICD codes differently than other countries, most have adopted some form of the

international version of ICD-10. In 2008 the Department of Health and Human Services (HHS) initially proposed ICD-10-CM and an implementation date of October 1, 2011 was set. Strong reaction from the industry that this did not provide enough time to implement resulted in the initially proposed implementation date (2011) being pushed back to October 1, 2013. Once the delay was announced, most healthcare entities put ICD-10-CM on the back shelf and only recently started looking at implementation requirements as the 2013 date gets closer. It's not surprising that since the additional two years was not used, many healthcare entities find themselves back at the table requesting more time. With another potential delay announced recently by HHS, a number of organizations have pulled funding and redirected efforts even before any delay has been announced. At some point, it becomes apparent that given more time for implementation, the trend is to stop work or slowdown work and not take advantage of additional time to prepare for a more effective implementation. Credible deadlines drive work, but unfortunately our track record has been to create deadlines that no one believes. Each delay results in a further loss of credibility.

"There are too many new initiatives and mandates."

Here is a statement that gets at the heart of the issue. There is little doubt that the number of new administrative and reporting requirements for clinicians has become overwhelming. Many small providers are joining larger organizations simply because of this overwhelming burden. ICD-10-CM, however, is foundational to support nearly all initiatives related to improvement of the healthcare delivery system. "Meaningful Use" becomes less meaningful if the definition of the patient health state is not well defined. Quality measures cannot get at expected outcomes or processes of treatment in a meaningful way if we don't have a better way to define the "What" and "Why" of healthcare delivery. If anything should be delayed, it should be those initiatives that rely on good data quality and instead, focus on improving data quality through better coding and definition of healthcare. If we delay ICD-10-CM there may be a considerable amount of re-work to factor ICD-10-CM into many of these initiatives in the future.

SUMMARY

There is no question that the implementation of ICD-10-CM will have an impact on the industry and require significant investment to get there. There are a number of reasons that have been put forth to suggest we should delay or avoid ICD-10-CM altogether. An open and informed look at where we are with our current coding of health conditions and inpatient procedures suggests that improvement in how we capture data about patients' health conditions and the institutional procedures done to improve or maintain those conditions is long overdue. It is a sad statement that in a country where healthcare is theoretically the most sophisticated in the world, we can't advance from a coding system that is 30 years old to something that is more consistent with the rest of

the world and twenty-first century. Without reliable information we will not know what to improve or if we actually reach the goal of better healthcare. ICD-10-CM is far from perfect, but it is a small step in the right direction.

ACTION ITEMS

1. Physicians need to have a broader understanding of the nature of ICD-10-CM, its challenges and advantages for them, their patients and the quality, efficacy and safety of the healthcare system.
2. Based on an assessment of the clinical documentation requirements, training, software tools and system should be developed to reduce the burden of proper documentation focused on good patient care through automated prompts and templates.
3. Strategies that focus more on good patient care and the advantages of ICD-10 for physicians and their patients should be used rather than focusing on "coding compliance".
4. Ongoing monitoring that focuses on metrics and feedback to assure:
    a. Better patient assessment
    b. Better clinical documentation
    c. Better coding
    d. Better information
    e. Better business