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ICD-10: THE TAIL WAGGING THE DOG

With the current focus on ICD-10 as a major transition impacting the industry, we seem to have lost site of the underlying goal of this effort; to improve the quality of healthcare data in this country for a wide range of uses. We tend to focus on ICD codes as administrative codes for payment transactions. These ICD codes are the only national, and to some degree international standard that we have to define the health state of the patient. Healthcare data cannot be very meaningful if the definition of the patient health state relevant to that data is not complete, specific, accurate and consistently defined. Interoperability of all healthcare stakeholders will be significantly compromised without a standard that meets these requirements.

What's at stake is not just a coding change, but the reliability of all health information as we move forward into a new data driven healthcare environment.

Healthcare in a Data Driven Environment

There is little doubt that policy makers believe that the fee for service environment is a key reason why healthcare in this country is three time more costly than virtually any other country. The only reliable data we have to compare value internationally (birth, death and longevity) does not indicate that we are getting proportional value for this extremely high price. We continue to assert that we have the best healthcare in the world, but we don't have the data to support that claim.

HHS recently announced aggressive targets for moving to a value based model for provider reimbursement. This model focus more on the nature of the patient condition and how care maintains or improves that condition rather than the specific services delivered. The belief is that more services do not necessarily equal better care. For this type of model to result in equitable payment, the definition of patient conditions must be far more complete, specific, accurate and consistently defined than it is today. This change in direction is creating a financial driver to improve data that defines the "why" of healthcare in a way that recognizes substantial difference in risk, severity and complexity to support reimbursement focused on the complexity of the problem and less on just service rendered. Accountable care models that look more at organizations taking financial risk for the care of a population will need to have risk adjustment models that recognize the risk, severity and complexity of the patient population.

Where does ICD-10 fit into this?

Unfortunately the belief that ICD-10 addresses the challenges we have with the quality of our current health data is wishful thinking.   ICD-10 provides an **opportunity** to be more specific, more complete, and more consistent and to represent more accurately the nature of the patient's conditions. Coding however can be just as vague in ICD-10 as it was in ICD-9. The critical factor in high quality data is not ICD-10. It is just a standard for reporting some of these key clinical concepts that make a difference in risk, severity and

complexity. Unless there is complete observation, accurate documentation and consistent coding of important clinical concepts, data will not improve. In this new data driven environment, ICD-10 is the provider's friend. It gives the provider the opportunity to report the details that make a difference in the assessment of cost effectives and care quality adjusted by parameters that make a difference. Hospitals have already discovered how small differences in documentation and coding can have a substantial impact on DRG payments. These differences will be magnified as DRGs and other forms of bundled payment factor into new payment weightings based on the enhanced ability to differentiate the complexity of the patient condition. Hospitals are making large investment in Clinical Documentation Improvement efforts and coding training, because they have realized the bottom line financial impact of these investments. These same impacts related to patient conditions are rapidly moving into the outpatient and professional environment.

What if ICD-10 doesn't happen, or gets delayed?

A lot of push back in the efforts to move to an ICD-10 environment is based on the belief that ICD-10 either might not happen or get delayed again, and that all of the effort to move in that direction will be wasted. Clearly any further delay would substantial hurt the opportunity to leverage some of the additional concepts supported by ICD-10, but the real focus is on observing and capturing the data needed to provide good patient care at the source. Good clinical documentation is agnostic as to the coding system. Good documentation goes well beyond any requirement of ICD-9 or ICD-10 or any coding standard. Complete observation and accurate documentation is what we were taught in medical school and residency. No new burden, just good care and what we signed up for.   We do need to renew our efforts to go back to the basics of high quality documentation regardless of whether the codes that captures those medical concepts are ICD-9 or ICD-10 codes.

Summary

While ICD-10 is currently a major area of focus, it's really the "tail wagging the dog". The real change is in the migration to a data driven, value based purchasing, accountable care environment. In that environment the details around medical concepts that make a big difference in risk, complexity and severity of the patient condition become more important in determining equitable payment and assuring that measures of quality and outcome take into account these differences. In this new data driven environment, ICD-10 is the provider's friend not the enemy.

ICD-10 is just an opportunity to capture these differences more effectively. Clinical documentation improvement is about good patient care and good patient data regardless of the standard used to capture that data. Clinical documentation improvement should not be code specific. It should be code agnostic. There is no new burden for documentation for ICD-10 over what we should be capturing today to provide good patient care.