ICD is the acronym for the International Classification of Diseases. The ICD is maintained by the World Health Organization (WHO) to classify diseases and other health problems recorded on many types of health and vital records such as death certificates. The ICD is periodically revised to incorporate changes in the practice of medicine. In 1990 WHO adopted the 10th revision (ICD-10). The WHO has ownership of the ICD system and the primary purpose has been for vital statistics and epidemiological data. ICD was first published in 1900 and ICD-9 was introduced in the US in 1979.

The “Administrative Simplification” subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the secretary of Health and Human Services (HHS) to adopt standards, including code sets, specifically for the electronic data interchange of health information for certain transactions, such as claims processing. HIPAA also requires the secretary to have procedures for the maintenance, testing, enhancement, and expansion of the code sets (ICD), as well as a process to get the input of providers, patients, and payers. The standards apply to health plans, health care data clearinghouses, and health care providers who transmit health information in electronic form.

The clinical modification of ICD-10 is referred to as ICD-10-CM, and it is intended to replace ICD-9-CM Volumes 1 and 2. These codes are used by physicians. The procedure coding system of ICD-10 is referred to as ICD-10-PCS, and it is intended to replace ICD-9-CM Volume 3. These codes are used by hospitals. When we speak simply of ICD-10 we are including both the CM and PCS parts. Our present ICD-9 system has approximately 13,000 codes whereas ICD-10-CM has 68,000 codes and ICD-10-PCS has more than 87,000 codes.

In January 2009 HHS published final regulations calling for a transition to ICD-10 and set October 1, 2013 as the compliance date. However, in late 2011 and early 2012 three issues emerged that led the secretary to reconsider the compliance date for ICD-10: 1) The industry transition to the version 5010 electronic operating system necessary to accommodate ICD-10 did not proceed as effectively as expected; 2) providers expressed concerns that other statutory initiatives were stretching their resources; and 3) surveys and polls of affected parties revealed a lack of readiness for the ICD-10 transition. As a result, in August 2012, HHS announced a delay of the implementation date for ICD-10 to October 1, 2014.

The latest compliance date for ICD-10 has been set as October 1, 2015, according to new regulation published by the Department of Health and Human Services (HHS) on August 4, 2014. This one-year delay in the implementation of ICD-10 came from language inserted into the Protecting Access to Medicare Act of 2014, which was signed into law on April 1, 2014. It said, “The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD-10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d-2(c)) and section 162.1002 of title 45, Code of Federal Regulations.”

While the AMA appreciates that physicians have additional time to comply with ICD-10, we continue to have fundamental concerns about ICD-10 and especially its implementation, which will not be resolved by the extra time. The AMA has long considered ICD-10 to be a massive unfunded mandate that comes at a time when physicians are trying to meet several other federal technology requirements and risk penalties if they fail to do so.

The organizations that are pushing ICD-10 include CMS, Advanced Medical Technology Association (AdvaMed), American Health Information Management Association (AHIMA), America’s Health
Insurance Plans (AHIP), American Medical Informatics Association (AMIA), BlueCross BlueShield Association, College of Healthcare Information Management Executives (CHIME), Health IT Now Coalition, Medical Device Manufacturers Association (MDMA) and 3M Health Information Systems. It is interesting that several years ago the insurance companies were not in favor of ICD-10 however as its implementation got closer and they spent millions of dollars to get ready they are now in favor of it (their change of support had nothing to do with how it will impact patient care but was purely a financial decision). All of these organizations (part of the industry) that are pushing ICD-10 have something to gain. No physician organization has supported moving to ICD-10 at this time and CMS does not apparently consider us as part of the industry. The financial gain of these industries will come at a steep cost to the physicians and patients in this country. Furthermore almost all of the reasons (advantages) given by CMS for the implementation of ICD-10 are not completely accurate and some are simply false and no one has addressed this concern. Statements by “industry” seem to always be taken as factual and “industry” never declares their conflict of interest in this subject matter.

These industry folks are spending a lot of time and money on this because they will eventually see a return on their investment. This return involves physicians buying and using their products and spending their own time and money trying to implement a system that will not benefit their patients. The ICD-10 system will only take more time away from their patients. The government will see a return on their investment because they will be denying more payments for care given by physicians simply because the physician gets the code wrong.

A small historical review can show you better what I am talking about. In Feb, 2009 legislation to promote the use of electronic records was signed into law as part of President Obama’s economic stimulus bill. This was after years of behind the scenes lobbying by well-connected players in the lucrative business of digital medical records. Now doctors are struggling to make the new record system work and at the same time are seeing rising costs with decreased productivity because of the new system. I spend an extra 2 – 3 hours every night at home just trying to finish entering all of the needed data into my patients’ records that I did not have time to do during the day. The only other choice I have is to cut corners and not document very well or to see fewer patients and lose money. The only clear winners in this game are the big companies that lobbied for the EMR legislation and have now seen their profits and sales soar to levels never seen previously. I suspect the same will be true with ICD-10 and that those in the industry demanding the implementation will financially benefit whereas physicians will have another new costly regulation thrown on them in addition to trying to implement EMR, the Affordable Care Act, electronic prescribing, physician quality reporting (PQRS), new HIPAA regulations and other government mandates.

AHIMA says ICD-10 will improve quality of care, support research, and move to a payment system based on quality. Physicians who have been using EMR for the last few years understand that none of this is completely truthful. The proponents and especially CMS say that the United States is the only major country that has not adopted ICD-10 however this is just another example of how they are not telling the whole truth. No other country has adopted all 87,000 codes as we plan to do. Canada only adopted 20,000 or so codes. No other country uses the ICD coding system as a basis of billing. No other country uses the ICD coding system in the outpatient setting and no other country puts the cost of the system squarely on the shoulders of the physicians. Why doesn’t CMS and others tell the whole truth? They are more interested in the financial fallout of the coding industry if we do not adopt ICD-10 and they don’t seem concerned about the physicians or patients.

In 2008 the predicted cost to implement ICD-10 ranged from $83,290 for a small practice, $285,195 for a medium practice and $2,728,780 for a large practice. Based on new information, a 2014 study found the following cost ranges for each practice size based on variable factors such as specialty, vendor and software.
Small practice: $56,639 - $226,105
Medium practice: $213,364 - $824,735
Large practice: $2,017,151 - $8,018,364

A small practice is 3 physicians. A medium practice is 10 physicians with one full time coder, and a large practice is 100 physicians with 10 full time coders and 54 medical records staff. Basically the Federal Government is sticking each physician with a huge tax ranging anywhere between $20,000 and $80,000 for the privilege of practicing medicine the way Uncle Sam tells you to do it.

The actual transition to ICD-10 will be complicated. The above costs are astronomical however what is more important to realize is that if you are not ready, and if all of your vendors are not ready on Oct. 1, 2015 and if everything doesn’t work perfectly on that one day then your income plummets to zero, and if you do not have a friendly banker then you are out of business. Did things work on 10/1/13 with the implementation of the exchanges? Even something as simple as implementing the “Sunshine Act” website for physicians has not worked well.

CMS recognizes that the ICD-10 transition will have an impact on the physician reimbursement processes and they have said so in their publications. CMS estimates that in the early stages of implementation, denial rates will rise by 100 to 200 percent and audits by the OIG will also increase. They have said that physicians should have savings to keep their practices going for 4-6 months which is ridiculous. Besides the potential changes in reimbursement policies, there will also be disruption due to physician and plan issues in the implementation of ICD-10. In a survey nearly 95 percent of AHA member hospitals reported that they were moderately to very confident of meeting the October 1, 2014 deadline but also noted that their success would depend on the readiness of payers and technology vendors. The success of this flawed implementation system is out of physicians hands even if they try to prepare. The bottom line is that the flawed implementation process will put a lot of physicians out of business and patients will lose access to care. For the most part these will be rural doctors in 1-2 physician practices and older physicians who just can’t do it.

Skeptics question whether the level of detail in ICD-10 is even necessary. For example, is it necessary to know that an injury occurred in a chicken coop or that the cause of injury was a knitting needle? Do you need to know that the patient was bit by an Orca whale the first time or the second time? What is the chance the doctor will get the code for diabetes correct when there are 250 codes?

The AMA has bent over backwards to help President Obama’s administration and CMS with many health care initiatives including the ACA. The implementation of ICD-10 in its present form should be stopped. The desires of industry should not be placed over the desires of the practicing physicians in this country. There are several possible implementation alternatives that would protect the medical profession. The first step at this time is to get a 5 year delay in ICD-10 implementation in order to fix it appropriately and allow physicians time to better introduce the complex EMR’s into their practices.

The following are long term possibilities to consider:

1) Uncouple the ICD diagnosis code from the CPT code that we use for billing. This would allow physicians to code for their services as usual and they would continue to be paid as usual on the new date of implementation. Physicians would start the new ICD-10 coding on the day of implementation however would not be penalized for coding mistakes or mistakes that happen in the system that may not even be their fault because the payment for services will not be based on the code. We are the only country that couples the ICD code with payments. Why should the diagnosis impact on our payment? Along with uncoupling we should also decrease the massive number of codes as Canada did.
2) We could use ICD-9 and ICD-10 concurrently for a year so that physicians and the industry could slowly adopt ICD-10 and work out the problems. CMS has concluded that concurrent use of both ICD-9 and ICD-10 (at user discretion) would be overly complicated, confusing, and costly most likely because of their antiquated computer system. This still needs to be looked into more thoroughly.

3) We could cold Turkey adopt ICD-10 on 10/1/15 and CMS could simply say they will not penalize physicians for mistakes in the first year (grace period). The concern is what would other payers do?

4) We could scrap ICD-10 all together and wait for ICD-11. When the WHO introduces ICD-11 in 2017 then let’s all work together to make the appropriate changes for the United States’ clinical modification and work with one goal to implement this in the early 2020’s after the Affordable Care Act is fully in place and after physicians have had more time to fully implement their EMR’s.