ICD-10: Will It or Won’t It Happen in 2015?

Don’t for one minute assume that ICD-10 will be delayed again.

BY HARRY GOLDSMITH, DPM

Welcome to Codingline Particulars, a regular feature in Podiatry Management focusing on foot and ankle coding, billing, and practice management issues.

Like many of you I’m getting a little tired hearing the arguments for the implementation versus delay of ICD-10. I thought the issue was a done deal in 2013 (you can write that down, chisel it in stone), 2014 (you can write that down, chisel it in stone), and 2015 (you can write that down, chisel it in stone). Now, the American Medical Association, one of the earliest proponents for ICD-10 implementation, and some state and regional medical societies are once again pushing Congress to delay (eliminate?) ICD-10 implementation. This time, they are asking for a two-year delay. The following are excerpts from a “Dear Representative” sample letter offered by the Texas Medical Association on its website to its members to send to their respective politicians. I have added my comments.

“Too high a price to pay: For physicians, there are about 68,000 diagnostic codes under the new ICD-10 coding system, which is five times more than are in use today under ICD-9. The United States is the only country in the world that ties this coding system to a complex billing system.”

While it is true that there are 68,000+ codes in ICD-10-CM, the letter has it wrong. The billing system really doesn’t change as much as it is impacted dramatically by the complexity of adding tens of thousands of codes as the 7th character extension (e.g., encounter status, episode of care) and 6th character laterality specificity (e.g., right, left, bilateral) reporting. These 6th and 7th character codes represent redundant information already captured in the medical record and, in some cases, as CPT/HCPCS modifiers on the same claim form as the ICD-10 code is reported.

“Experts, including the Centers a delay in payment for claims with dates of service October 1, 2015 and beyond, the previous two delays in ICD-10 implementation have given all the stakeholders (albeit not necessarily at the practice level) multiple opportunities to test the software and process. Even if an individual payer’s computer software gets a glitch, it would be limited to claim processing by that payer and not be a widespread disaster involving all payers. In other words, a physician’s income would not drop to zero. As a matter of fact, account receivables from prior to October 1, 2015 and beyond, the previous two delays in ICD-10 implementation have given all the stakeholders (albeit not necessarily at the practice level) multiple opportunities to test the software and process. Even if an individual payer’s computer software gets a glitch, it would be limited to claim processing by that payer and not be a widespread disaster involving all payers.

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only Medicare (and other government agencies), but non-Medicare payers.

So, from a development/transitional standpoint, theoretically, they are ready to go. By the way, Texas Medical Association, exactly how would a two-year delay in ICD-10 implementation change your experts’ predictions over non-payment for up to six months? What solutions are you proposing?

“The costs of shifting to ICD-10 are significant. The transition to ICD-10 is expected to cost $1.64 billion over 15 years, with more than 43 percent of that coming from the cost of upgrading information technology systems. That cost is spread across multiple participants—government ($315 million), payers ($164 million), physicians and providers ($137 million), and software developers ($96 million). Physicians will be the hardest hit for much of the remaining 57 percent of the cost of implementing ICD-10: we will spend $356 million and lose $571 million from decreased productivity.”

Well, those are a lot of numbers being thrown around without any citations or references. We don’t know if they are old or up-to-date numbers. Are any of those costs the result of hardware/software upgrades for PQRS or for meeting electronic medical record mandates and meaningful use requirements? If the cost is really $1.64 billion over 15 years, how do you explain the widespread reporting that the delays in ICD-10 implementation, so far, have cost $6.6 billion dollars to the same multiple participants?

As far as productivity, we know from studying (report from the American Health Information Management Association and the American Hospital Association) Canada’s transition from ICD-9-CA to ICD-10-CA (which only includes 17,000 diagnosis/procedure codes versus over 120,000 in the United States version) between 2001 and 2004 that professional coders experienced “just under” 50% productivity (coding) rates one month post-conversion and a return to only 81% productivity for hospital chart coding, 79% for day surgery, and 85% for emergency department after one year. The point of the report is that not only was there a measured loss of productivity in the coding (which translates to cash flow issues), but also there is a trickledown effect negatively impacting productivity within the clinical practice. So, implementing a 68,000+ code ICD-10-CM will without a doubt impact productivity and revenue.

“…the timing of the transition could not be worse. My staff and I are struggling right now to meet many other government-imposed administrative hurdles, including implementing and achieving meaningful use of electronic health records, meeting quality measures under Medicare’s Physician Quality Reporting System, and other programs. Please help me take care of my patients. Please take action immediately to stop ICD-10 implementation.”

Ah, now we are getting to a very valid point. The Texas Medical Association, in my opinion, threw a Hail Mary and is running for the goal only to fumble on the one-yard line by including the last sentence. It is not ICD-10-CM that needs to be stopped per se—the letter introduced what is a clear and present source of frustration in today’s physician practices: government-mandated implementation of requirements that may or may not impact healthcare outcomes in the United States—meaningful use of electronic health records and PQRS penalties. The letter should have gone beyond introducing the physician “struggle” with these. It should have implored the congressperson to act to suspend them as a mandate.

My Response

On December 6, 2014, Medical Economics published online a brief article (“Another ICD-10 Delay Could Be Looming”) that included the link to the complete sample letter from the Texas Medical Association. I thought someone needed to comment, and there happened to be an online comment section that followed the article…so I wrote:

“Has anyone noticed that the Texas Medical Association’s sample letter, while imploring for a 2-year delay in implementation of ICD-10-CM fails to offer any hope that 2 years from now it won’t produce another letter to be sent to representatives? There is no ‘in the next 2 years, phy-sicians will be in a better position to implement ICD-10.’ In fact, asking for a delay ICD-10 does nothing other than delay ICD-10. If the issues are 68,000+ diagnostic codes, workflow slowdown, productivity hits, glitches in the processing chain, AND meeting “many other government-imposed administrative hurdles, including implementing and achieving meaningful use of electronic health records, meeting quality measures under Medicare’s Physician Quality Reporting System, and other programs”, I would suggest physicians and other healthcare providers not push for another delay in implementing a needed coding system (one we will absolutely need to replace ICD-9), but instead push for:

1) Elimination of the 7th character and laterality (in the 6th character) of ICD-10. The United States is the only country to have a 7th character and laterality, and other than for data mining purposes (government, payers, researchers), that extra information which is redundant since it exists in the medical record and in some cases as modifiers on CPT/HCPCS coding, does not change patient treatment outcomes. By the way, eliminating the 7th character and laterality characters, drops ICD-

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10-CM from 68,000+ codes by probably less than 50%...and will be similar in use as ICD-9 so implementation and acceptability will be less contentious...and CDC/CMS can, in the future if they feel the need, activate the later-

city/7th character edits once providers and vendors feel comfortable in the ICD-9 to ICD-10 switch;

2) Eliminating the disincentives and penalties imposed on providers through government-mandated programs like PQRS, meaningful use, and others. It would be reasonable to ask: Where, given the years the programs have been in place, are the published studies that prove that the government’s mandates have actually significantly improved physician quality and patient outcomes? And if there are no studies that validate significant patient outcome improvements, whether by the program(s) as a whole or in-

dividual measures or elements, they—the programs or the measures—should be eliminated as a mandate until such time as the cost versus value of such government (and private pay-for-performance) programs show significant actual healthcare value. These are things physicians and other healthcare providers should be pushing.”

Can you imagine how easy it would be to implement ICD-10 without laterality and without the 7th character extension? Do you realize that most of the potential glitches would disappear? Wouldn’t it be nice to have a single page charge ticket (paper or electronic) again? So what are you waiting for? Spread the word. Reach out and propose these two fixes to your senators and congresspersons...and to your MD/DO colleagues.

Meanwhile, don’t for one minute assume that ICD-10 will be delayed again. Follow the transition timeline to prepare your office’s doctors and staff. Just remember, ICD-10 will be here October 1, 2015. You can write that down, chisel it in stone.

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Dr. Goldsmith of Ceritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.