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Health Policy Brief

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Transitioning to ICD-10. Health plans and providers prepare to begin using a revised coding system to track diagnoses and procedures.

WHAT'S THE ISSUE?

On October 1, 2014, all health plans, health data clearinghouses, and health care providers that transmit health information electronically were to be required to use a new, significantly broader, coding system, called ICD-10, for diagnoses and inpatient procedures. However, on March 31, 2014, Congress passed legislation prohibiting implementation of the requirement for at least one additional year: not before October 1, 2015. President Barack Obama signed it into law on April 1, 2014. The Centers for Medicare and Medicaid Services (CMS) has indicated that it intends to establish October 1, 2015, as the new ICD-10 implementation date. The use of the ICD-10 coding system has the potential of improving the health care system, but its costs and complications have caused some to question whether the costs outweigh the benefits.

WHAT'S THE BACKGROUND?

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. It is used to monitor the incidence and prevalence of diseases and other health problems. The ICD is periodically revised to incorporate changes in the practice of medicine. In 1990 WHO adopted the 10th revision (ICD-10).

In the United States, ICD-10 has been used since 1999 to code and classify mortality data from death certificates. However, a modification of the 9th revision (ICD-9) is still used to assign codes to diagnoses associated with inpatient, outpatient, and physician office use and for inpatient procedures. Currently, the United States is the only G7 nation (the other G7 nations are Canada, France, Germany, Great Britain, Italy, and Japan) continuing to use ICD-9.

ICD-9 was expanded in 1977 by the US National Center for Health Statistics (NCHS) to provide more detail for reporting illnesses (morbidity). It is referred to as ICD-9 clinical modification (ICD-9-CM, Volumes 1 and 2). Around the same time, CMS developed a volume for inpatient hospital procedures (ICD-9-CM, Volume 3). These modifications and expansions are nearly forty years old and are outdated, representing the practice of medicine a half-century ago. The coding system is near capacity, requiring that some new codes have to be added to topically unrelated categories, such as having to add a heart procedure to the eye chapter because the heart chapter has used all possible combinations. Within the system, some codes have been moved, causing confusion among researchers attempting to conduct longitudinal analyses. The codes also

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lack sufficient detail. For example, ICD-9-CM has a single diagnosis code for fracture of the wrist. If a patient is treated for two successive wrist fractures, the ICD-9-CM code does not provide enough detail to determine if the second fracture is a repeat fracture of the same wrist, a fracture of the other wrist, or nonunion or mal-union of the original fracture.

ICD-10 is able to accommodate new diagnosis and procedure codes for future clinical protocols that can improve quality measurements, patient safety, and evaluation of medical processes and outcomes.

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. It was developed over many years by the NCHS following a thorough evaluation by a technical advisory panel and extensive consultation with physician groups, clinical coders, and others to assure clinical accuracy and utility. ICD-10-CM represents a significant improvement over ICD-9-CM. It provides additional information relevant to ambulatory and managed care encounters; expands injury codes; includes combination diagnosis and symptom codes to reduce the number of codes needed to fully describe a condition; and identifies the side of the body involved (laterality). The ICD-10-CM codes use three to seven characters, the first of which is a letter and the remainder are numbers. This is different from the three to five numbers used in ICD-9-CM and expands the number of codes more than fivefold, to approximately 68,000.

CMS used a similar process to develop the ICD-10-Procedure Coding System (PCS), intended to replace ICD-9-CM Volume 3. ICD-10-PCS uses seven alpha and numeric characters per code and has more than 87,000 diagnosis and procedure codes. ICD-10-PCS is sufficiently detailed to describe complex medical procedures with unique, precise codes that differentiate body parts, surgical approaches, devices used, and qualifying information.

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WHAT'S IN THE LAW?

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, 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.

In August 2000 HIPAA regulations were finalized that established ICD-9-CM Volumes 1, 2, and 3 as the standard code sets for electronic data interchange to use in tracking diagnoses and inpatient hospital procedures. The code set requirements affect diagnosis coding in all US health care settings and coding of procedures in inpatient hospital settings. They do not directly affect coding for outpatient procedures and physician services. Although there may be some indirect effects resulting from changes in diagnosis coding. The final rule included a discussion of transition to ICD-10-CM and ICD-10-PCS (which together, will be referred to simply as ICD-10 for the remainder of the brief) as the standard code sets sometime in the future.

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. It required that ICD-10 codes be used for services provided on or after October 1, 2014, and that ICD-9 codes would be used for services provided before that date. Implementation of the conversion to ICD-10 was again postponed when, on March 31, 2014, Congress passed legislation that prohibits implementation of ICD-10 prior to October 1, 2015.

CMS has an ICD-10 website where providers, payers, vendors, and other affected parties can access official resources to help in the transition to ICD-10. Included are fact sheets, checklists, and timelines as well as a Web-based tool that provides step-by-step guidance for small and medium practices, large practices, small hospitals, and payers. Also on the ICD-10 website, CMS has indicated that it expects to issue

an "interim final rule" in the near future that will require the use of ICD-10 beginning October 1, 2015, and require that ICD-9 continue to be used through September 30, 2015.

CMS also had adopted a four-prong approach for testing to ensure that it as well as the provider community was ready for the ICD-10 transition originally scheduled for October 1, 2014. First, CMS had conducted internal testing of Medicare fee-for-service (FFS) claims processing systems, and, as of October 1, 2013, it had determined that all such systems were ready for ICD-10 implementation. CMS continues to test any software changes. Second, CMS is providing beta testing tools that providers may use to test their own readiness. Prior to the delays, any providers who determined that their systems would not be ready to convert on October 1, 2014, were encouraged to use free billing software offered by Medicare administrative contractors to submit Medicare FFS claims. Third, CMS offered acknowledgment testing to allow providers to determine whether CMS will be able to accept their claims. Finally, CMS had planned to involve a small sample group of providers in end-to-end testing of the entire claims process. The end-to-end testing that was scheduled to be done in July 2014 has been postponed until 2015, but no specific dates have been set.

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WHAT'S THE DEBATE?

Conversion from ICD-9 to ICD-10 is complicated and costly, causing some affected parties to question whether the benefits of the conversion outweigh the costs. Experts say the new code set will have an impact on not only claims submissions but also such processes as patient eligibility verification, preauthorization for services, documentation of patient visits, research activities, and public health and quality reporting. Not only must new software be installed and tested, but training for physicians, staff members, and administrators is required. New practice policies and guidelines must be developed and paperwork and forms updated.

Proponents of the transition to ICD-10, including the federal agencies that developed the system, say the codes will provide a more exact and up-to-date accounting of diagnoses and hospital inpatient procedures, which could improve payment strategies and care guidelines. Codes describing the circumstances of injuries are important for public health researchers to track how people get hurt and try to prevent injuries. More precise information and detail will improve claims processing by reducing requests for additional information and providing more accurate reimbursement. The expanded structure of the code sets provides space to accommodate future developments in medical practice and technology. More detail will enhance quality outcomes measurement and value-based purchasing programs. It is hoped that, ultimately, better clinical and business intelligence, derived from ICD-10 data, could stem the rising cost of health care by driving evidence-based clinical treatment programs. And, the use of ICD-10 may improve interoperability for the exchange of data with other countries for research and other purposes. Other countries have adopted their own ICD-10 modifications, however, so some effort will continue to be necessary for international comparisons.

Furthermore, proponents argue that forgoing the change to ICD-10 at this point in time would translate into a loss of billions of dollars for the US health care industry in what has been invested or budgeted to date. Many of the largest health care systems report that they have already spent considerable resources to meet the October 1, 2014 deadline. Some were ready to convert on October 1, 2013. A health care industry group called the Coalition for ICD-10—American Hospital Association (AHA), Blue Cross Blue Shield Association, American Health Information Management Association, and College of Health Information Management Executives—argued in Congress against any further delay. In a July 2013 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.

Notably, the cost, just in terms of training staff, is considerable and well into the millions of dollars for large health care facilities. Learning a new coding system and then delaying its implementation, as happened in 2013, makes it difficult to recapture costs, especially if there is another delay. Moreover, those who wanted to hold firm to the October 1, 2014, timeline argued that if there is another delay, existing and future budgets to implement ICD-10 may have to be reduced or replaced with more pressing initiatives.

Opposition to implementation of the ICD-10 transition in 2014 came primarily from medical associations, including the American Medical Association (AMA). They believe that the

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transition will be overly burdensome on providers who are already engaged in efforts to comply with new systems and requirements such as meaningful use, e-prescribing, and quality data reporting. In response to the legislation delaying implementation for at least a year, the AMA said that it and other physician organizations welcomed the temporary relief but would remain committed to relieving physicians of the crushing administrative burdens and practice disruptions that are anticipated during the scheduled transition to ICD-10.

They cite costs as a major problem. Estimates regarding the additional costs of the implementation of ICD-10 have varied, but one study in 2008 sponsored by the AMA, the Medical Group Management Association, and other provider associations has pegged the adoption costs for a small practice at $83,000, ranging up to $2.7 million for a typical large practice. The study identified costs in six key areas: staff education and training, business process analysis, new claims form software, IT system changes, increased documentation costs, and cash flow disruption. A February 2014 update of the study takes into account changes in the regulatory environment, and some real-world experience found that costs may actually be higher: up to $226,000 for a small practice and in excess of $8 million for a large practice.

A September 2010 estimate from America's Health Insurance Plans (AHIP), the industry trade association, estimated that "total system-wide cost" just for health insurance companies would likely be in the $2-$3 billion range. Average per member implementation costs would range from $38 for small health plans (fewer than one million members) to $11 for large plans (more than five million members).

Skeptics also question whether the level of detail in ICD-10 is 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?

Finally, critics point out that since the 11th version of the ICD is under development by WHO and is due for release in 2017, it might make more sense to postpone the conversion from ICD-9 until then.

In response to the issue of waiting for ICD-11, CMS says that is not feasible because work cannot begin on modifying ICD-11 for use in the United States until it's released, and then it takes five to six years to complete the process. This means rulemaking could not begin until 2020 at the earliest. Also, since ICD-11 is a modification of ICD-10, a transition from ICD-9 directly to ICD-11 would be even more complex and potentially more costly.

WHAT'S NEXT?

Given the political fallout from the data system problems encountered with implementation of the health insurance exchanges, the Obama administration will likely be extremely sensitive to any potential problems with claims processing due to the ICD-10 conversion. Extensive testing, both of the system's connectivity and of coding accuracy, is needed to ascertain readiness for the conversion. In February 2014 CMS administrator Marilyn Tavenner had announced that there would be no further delays and implementation would proceed on October 1, 2014. However, since Congress responded to physicians' concerns and again delayed implementation for at least one year, the administration and providers must deal with the implications of the delay and revise plans for training and testing. While the delay will be costly for organizations that have already made substantial investments in preparing for the change, it may also provide more time to make sure the transition occurs more smoothly. ■

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Written by
Julia James
Health Policy Consultant

Editorial review by
Christopher G. Chute
Professor of Medical Informatics
Mayo Clinic

John Casillas
CEO, Board Trust
Global Health IT Fellow, World Bank

Rob Lott
Deputy Editor
Health Affairs

Tracy Gnadinger
Assistant Editor
Health Affairs

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