A Minor Rant About ICD-10

BY PATRICIA KROKEN, FACMPE, CRA

i'm preparing for the announced ICD-10 compliance date of Oct., 2014, and trying to buy into the "blah, blah, blah" about how much better the healthcare system will be in terms of improved case management and all of the other wondrous things we'll be able to do with the extra data that we can't currently generate with ICD-9. In my practice, we've trained our coders to the extent they can be trained at this point, have confirmed with the billing software vendor that the system will be ICD-10 compliant and will test according to schedule. The radiologists have been informed they will need to dictate all kinds of additional (useful) information into their reports. They're pretty good at documentation now so I'm sure we'll be ready for spacecraft accidents, parrot bites and turtle incidents.

The history and "need" for ICD-10 usually revolves around the fact we have run out of numbers and descriptions with ICD-9 and need to catch up with the rest of the world. (Not that we can get decent information for dictation and coding from existing referring physician orders at the present time—but I'm sure it will be *much* better when the new codes are in place!)

Administrative simplification

The primary goal of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was to provide for "administrative simplification," although the complexities of complying with the resulting privacy and security regulations have always placed that intent in question (nothing about it is or has ever been simple). The Transaction and Code Sets Standards (TCS) portion of HIPAA was at the core of administrative simplification, designed to standardize the claims submission process and all related types of communication. Rather than having insurance companies each dictate a format and "language," HIPAA/TCS gave us a standard language. ICD-9 (and CPT-4) represented standard "code sets" as does ICD-10. Standard formats were established with the 4010 guidelines.

For those of us around for the TCS compliance date, we found ourselves held accountable for mysterious drops in revenue. The software vendors blamed it on the clearinghouses and the insurance carriers went through a game of "we didn't get the file." At that time, we worked with a legacy software platform and the vendor would contact us with message stating "Three weeks ago a file failed to transmit to XYZ Insurance. We have taken care of the issue and there is nothing you need to do." Of course three weeks prior we had confirmation that the file was successfully sent and were expecting payment. The excuses were rampant, cash flow was lagging and some of us still haven't recovered from scars incurred as radiologists extracted pounds of flesh for our changing stories of how collections were/weren't going.

We felt a minor level of déjà vu when the 5010 standard was implemented. We worked with our vendors. We tested. "We're ready," said the insurance companies! They weren't. And claims processing again fell on its nose, although this time with lesser scrapes and bruises.

The standardized process was indeed designed to simplify our lives and in fact over the years it has. Electronic payments are processed more quickly, days in A/R have dropped and it is easier to manage the claims follow-up process.

So what aspect of ICD-10 falls within the administrative simplification goals? Note: To date there have been virtually no promises our lives will be made easier with the implementation of ICD-10.

Unanswered questions...and (near) future risks

Coding proponents cite the fact the United States is far behind the rest of the world with its reliance on primitive ICD-9 codes.

What they don't state is that we are so sophisticated, we've added thousands of codes to our version of ICD-10, which differs from the International Version.

"Much of the new system is based on a World Health Organization code set in use in many countries for more than a decade. Still, the American version, developed by the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services, is considerably more fine-grained.

The WHO, for instance, didn't see the need for 72 codes about injuries tied to birds. But American doctors whose patients run afoul of a duck, macaw, parrot, goose, turkey or chicken will be able to select from nine codes for each animal, notes George Alex, an official at the Advisory Board Co., a health-care research firm.

There are 312 animal codes in all, he says, compared to nine in the international version. There are separate codes for 'bitten by turtle' and 'struck by turtle.'[1]

So here we are, ready to enthusiastically embrace a whole, unique-in-all-the-world specificity for coding to a system where it can be difficult to get "cough" as a symptom for a chest x-ray. We have already been told it is unlikely our current coders have the required knowledge in anatomy and physiology and that coding productivity will drop drastically—and nobody has done this at the level proposed in the U.S.

That doesn't even begin to address the potential issues related to getting these claims processed! Will Blue Cross be happy just knowing the bite came from a macaw or will they want one of the 9 more specific codes? Will they deny the claim because it's obvious the person was struck by a turtle and not bitten by one?

Where will the buck stop?

So let's say we're on the ICD-10 starting line and ready—coders trained, software updated and tested, big checks written to the coding consultants. If the first rounds of HIPAA were any indication, radiology will be ready and primary care (and many other referring specialties) clueless. We'll be calling them for clarification regarding "struck by turtle" versus "bitten by turtle" and they'll be saying "Whaaaaaaat?" (Remember what we went through convincing them we were part of the patient's circle of care under HIPAA and therefore authorized to share patient information for purposes of treatment, payment and healthcare operations?)

Will local coverage determinations be rewritten to each include another 1,000 pages of acceptable diagnosis codes to accommodate the expanded list?

Will the insurance companies have all edits in place to adjudicate new layers of coding or will they in fact require a lesser degree of specificity than what is available in the coding manual? Will their people who have trouble understanding why there can be multiple chest x-rays on the same day get the same level of anatomy/physiology training as our coders?

At a time when the administrative and documentation requirements of burgeoning regulations mean that referring physicians have to see more patients every day just to stay in business, how can we in all conscience require such a documentation burden be stacked on?

Why do we have to have more codes than other countries in the world? Are we showing off? Based on the valuable reports that have been initiated from collecting PQRI/PQRS data for several years (ha!), I'm sure in about 10 years there will be a very valuable government study costing $2 billion and showing most parrot bites occur on pirate ships.

Rant over. Now I'll work on my normally optimistic attitude again which will include learning to love absurdity. I'll keep reminding myself of one of my favorite sayings, "Never seek logic in healthcare." If I intended to retire, however, it would be in October 2014.

RESOURCES

1. "Walked into a Lamppost? Hurt While Crocheting? Help is On the Way." Wall Street Journal, Sept. 13, 2011. http://online.wsj.com/article/SB10001424053111904103404576560742746021106.html

PATRICIA KROKEN, FACMPE, CRA, FRBMA is a principal in Healthcare Resource Providers, a radiology business consulting firm. She is a regular contributor to industry publications and a frequent speaker on topics related to radiology practice management and HIPAA. *Patricia can be reached at Healthcare Resource Providers, LLC, PO Box 90190, Albuquerque, NM 87199; 505.856.6128; pkroken@comcast.net.*