ICD-10 Rollout Relatively Smooth, Insurers Say

On October 1, 2015, the medical coding tool International Classification of Diseases, Tenth Edition (ICD-10) went into effect, replacing the previous coding version, ICD-9. The ICD is a medical coding tool utilized by doctors and other providers for clinical and health management purposes, as well as monitoring diseases and other health problems, in order to provide a picture of the general health situation of patients. The initial launch of ICD-10 has largely been seen as a success by many healthcare industry stakeholders. Sid Hebert, head of Humana’s ICD-10 implementation team, stated “it’s been a pretty smooth transition so far.” While not all insurers have experienced the same success as Humana, most observers noted that any issues that arose were quickly resolved by regulators at the Centers for Medicare and Medicaid Services (CMS). This Health Capital Topics article will discuss initial reactions regarding the ICD-10 rollout; the impact ICD-10 may have on patient satisfaction, reimbursement, and physician productivity; and, potential issues related to ICD-10 implementation, such as an increase in the number of claims and administrative load.

One of the intended benefits of the ICD-10 coding system is to facilitate more accurate claims, decreasing the number of denials and underpayments of reimbursements, and increased efficiency in billing and reimbursement processes. The ICD-10 coding system contains two elements: (1) a clinical monitoring (CM) element, which was developed by the Center for Disease Control and Prevention (CDC) for use in the United States; and, (2) a procedure coding system (PCS) element, which was developed by the Centers for Medicare and Medicaid Services (CMS) to be used only in inpatient hospital settings. Medical codes under the ICD-10 coding system are between three to seven characters long, with the fourth through seventh digits providing more specificity in anatomical site and severity. The structure of an ICD-10 code varies significantly from its ICD-9 predecessor. For example, coding for cardiovascular implementation of grafts under the ICD-9 coding system utilized only one code: 996.1. Under the ICD-10 coding system, there are eight codes for the complication of vascular grafts, allowing the physician to specify whether a breakdown, leakage, or displacement of the graft exists as well as which artery is affected. Examples of these codes under the ICD-10 coding system include: (1) T82.311A (a breakdown of a carotid arterial graft); and, (2) T82.524A (displacement of an infusion catheter). The new codes also allow physicians to provide more detail on when a patient is seen or how treatment is progressing. For example, the ICD-10 coding system allows physicians to specify whether a right or left wrist was broke, a functionality not available in the ICD-9 coding system.

Even though the updated ICD-10 coding system expanded the number of diagnostic classifications available to healthcare professionals (from 13,000 under the ICD-9 to 68,000 under ICD-10), the transition from the ICD-9 coding system to the ICD-10 coding system has been largely viewed as successful. Humana noted its call centers have received few calls in regard to issues related to submitting claims based on the new medical coding system. Further, the few problems that providers have experienced have been resolved with limited interruption to provider operations. For example, many home healthcare and hospice care providers experienced an issue in which all of their Medicare claims were rejected as being “noncompliant.” When alerted of the issue, CMS advised that, until the system is corrected, CMS would manually process all home healthcare and hospice claims in order to maintain provider cash flow. Additionally, two smaller, unnamed insurers reverted back to ICD-9 codes as a result of information technology (IT) system failures during the rollout; however, the acceptance rate of the claims filed by the insurers above remained similar to acceptance rates under ICD-9.

The ICD-10 coding system may have a long-term impact on a number of areas within healthcare delivery, including: (1) patient satisfaction; (2) provider reimbursement; and, (3) physician productivity. First, patients may feel the impact of the new ICD-10 coding system in numerous respects. The ICD-10 coding system is meant to improve the ability to measure the provision of medical services and decrease the need for supplemental documentation for claims; however, patients may notice many of the indirect effects of streamlining administrative and billing processes, including improved transparency of medical costs due to an enhanced ability to differentiate between costs of treatment options.
ICD-10 is also expected to impact many aspects of provider reimbursements. Currently, inpatient services are grouped into diagnostic-related groups (DRG) through the use of grouping software programs and are central to the payment process. With the implementation of ICD-10 coding system, new DRG group methodologies will be utilized to translate new codes into DRGs for payment. The change from ICD-9 to ICD-10 was thought to alter the amount of reimbursement for the provision of medical services, on the logic that increased specificity in coding could either lead to higher or lower reimbursements. However, a report issued by the Journal of American Health Information Management Association (AHIMA) stated that the impact on DRG-based reimbursement may not have the effect it was originally expected to have in regards to Medicare inpatient hospital payments. The AHIMA report states that the “Medicare inpatient prospective payment system (IPPS) uses the Medicare Severity-Diagnosis Related Groups (MS-DRGs) as the basis of payment,” and the ICD-10 MS-DRGs are a replication of the previous codes. Because of this replication, ICD-10 MS-DRGs do not utilize the increased specificity in the ICD-10, which resulted in 1.07 percent of patients being assigned to different codes due to the differences between ICD-9 MS DRGs and ICD-10 MS-DRGs. Since there is a lack of valuable ICD-10 data, MS-DRGs are not able to take advantage of the specificity the ICD-10 coding system offers, making the changes in payment due to a change in MS-DRG less than expected. While further analysis on this issue is expected in the future, the effect of ICD-10 implementation on IPPS reimbursement levels may be less than expected.

Additionally, physicians fear that the increased specificity of the ICD-10 coding system will negatively impact their productivity. For example, physicians fear that utilizing the ICD-10 coding system will result in the disruption of workflow due to the need to train staff on the new coding system. Demonstrating the legitimacy of physician concerns, a study conducted by the AHIMA Foundation found that the time spent coding an inpatient record increased by 17.71 minutes utilizing the ICD-10 coding system over the ICD-9 coding system, resulting in a 69 percent increase between the two systems. However, the study noted that physician decreases in productivity are expected to follow a bell curve, with its peak having already occurred at the rollout date of the ICD-10 coding system. As efficiency improves in utilizing the ICD-10 coding system, the productivity will steadily increase. Follow-up research is expected to determine the long-term effects of the new ICD-10 coding system on physician productivity.

The rollout of ICD-10 coding system has raised concerns that the problems experienced will continue to appear in the future. One concern has been the increase in the number of codes the ICD-10 utilizes. As stated previously, the updated ICD-10 coding system expanded the number of diagnostic classifications available to healthcare professionals from 13,000 under the ICD-9 to 68,000 under ICD-10. However, no clear crosswalk system between the former code and new code exists to ease the transition into the ICD-10 coding system. Additionally, the conversion to the ICD-10 coding system has led to increased capital expenses for health insurers over the past two years in preparation costs. These costs are attributable to installing needed technology, including software programs, as well as any maintenance on systems to keep them in operating condition. While one solution may be to hire additional medical coders to alleviate the time spent hunting codes down, there has been a shortage of coders, making this solution less feasible. An increase in the administrative load may create other problems, such as a backlog of claims from the previous coding system. Additionally, the lack of coding specialists with the proper training to utilize ICD-10 may impact coding accuracy, which could spike denial rates for claims that are noncompliant.

Overall, while the initial rollout of ICD-10 has been viewed positively, many uncertainties remain before deeming the transition a “success,” including concerns about limited physician productivity as well as a lack of medical coders trained in the new ICD-10 system. However, if the AHIMA’s prediction of rollout issues following a bell curve, with the growing pains being felt around ICD-10’s initial rollout, concerns regarding physician productivity and supply of adequate coders may decrease in the future. Monitoring productivity measures internally and reporting issues related to ICD-10 codes to the proper internal and external parties may help smooth the transition for providers into the future.

3 Ibid.
5 Ibid.
10 Ibid.

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(Continued on next page)
Ibid.


Ibid.


Ibid.

Spivey, October 25, 2015.

Ibid.


Ibid.


Gopal, October 1, 2015.


Ibid.


Ibid., p.2.

Ibid., p.4.
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