Testimony to the National Committee on Vital and Health Statistics Subcommittee on Standards Hearing – Section 7, ICD-10 Delay

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Thank you for inviting me to participate in today's discussion. As Chief Administrative Information Officer at Beth Israel Medical Center (BIDMC), my responsibilities include the Information Systems infrastructure and Health Information Management (HIM). I've also been co-lead on the ICD-10-CM/PCS implementation project in which BIDMC has been engaged for the past four years.

In tackling the ICD-10 project, we created four workgroups, each with a different focus.

- Technical Workgroup – Software remediation
- Vendor/Payer Workgroup – Contracts and payer testing
- Education and Coding Workgroup – Clinician education, documentation improvement, and assuring there is an adequate coding workforce
- Workflow – Alterations in operational policies and procedures made necessary by ICD-10

Although we made substantial progress on all fronts, we were appreciative of the extension that was announced in September 2012 to delay transition to October 1, 2014. The enormity of the project was as many industry experts speculated. It was "Y2K-like" in scope both in terms of cost and complexity.

We had good momentum as we approached October 1, 2014 and would have been able to complete the transition. There were a few areas that are described later in this statement where further work would make our transition more successful. For this reason, the reset date to October 1, 2015 was helpful.

Many, including myself, are appreciative of the important role the Standards Subcommittee has in promoting administrative simplification. What is troubling is the efforts do not appear to have impacted, in a positive way, the percentage of provider budget that is spent on administrative overhead. To the contrary, administrative overhead as a percentage of our medical center's budget has not declined since HIPAA was enacted. I suspect this is the case at other medical centers.

Similarly, I've not met a direct care provider who believes more time has been freed for patient care since HIPAA was introduced in 1996. Would these not be "acid tests" for whether or not "administrative simplification" has been successful?

I say this with trepidation as the reaction could be introducing an overhead cap similar to that done with the medical insurance community. Targeting the percentage of provider revenue devoted to administrative overhead would be a good thing, but only if the recommendations of the Standards Subcommittee are complimentary to that objective. Implementing ICD-10 is not complimentary.

The balance of my statement is a response to questions presented in earlier correspondence from the Subcommittee's staff.

1. **What are the main challenges, issues and risks associated with delaying implementation of ICD-10?**

   Response: As with any complex, challenging project, there was disappointment among some as we had good momentum. Although it was regretful in some ways, the delay announced with U.S. Senate's approval of H.R. 4302 was, on-balance, beneficial to our organization.

   On the negative side, the delay will require us to postpone or suspend some activities and schedule them for a restart in calendar year 2015. An example is dual coding that was planned to begin in April 2014. The delay also requires us to retrain our Bridge and Pipeline candidates (programs described in more detail later) in ICD-9. They were initially trained only in ICD-10.

   "The positive aspects of the March 31, 2014 delay outweigh the negatives."

   There may also be changes to technology, workflows, or business rules that occur between now and the ICD-10 reset date. These may require repeating some testing that would otherwise have been more efficiently completed this fiscal year.

   Nevertheless, the positive aspects of the March 31, 2014 delay outweigh the negatives. The delay will allow the newly minted coders to gain more experience and HIM can work with clinicians on documentation improvement.

   As we entered calendar year 2014, BIDMC was on a trajectory to successfully transition to ICD-10 on October 1, 2014. The Technical, Vendor/Payer, and Workflow Workgroups were doing well and, for the most part, ahead of schedule. The Education and Coding Workgroup, however, had concerns. The first was the sufficiency of coding staff to meet the demands of ICD-10. Early reports suggested a 50 percent loss of coding productivity. Our early trials coding medical records using ICD-10 bore out these predictions.

   This concern was made worse by a growing market demand for experienced coders. In the twelve months prior to the announced delay, we lost six of our most seasoned coders including four who were offered substantially higher pay by other companies. Additionally, we were experiencing escalating prices among our contract coding firms who began charging what the market would allow. Contract coding rate increases in the ten to twenty percent range were typical.

   Concerned about the pool of experienced, domestic coders, we began pursuing off-shore contract coding services. This was Y2K redux.[1] The delay to October 1, 2015 caused us to push the "pause button" on this.

[1] Perhaps not for the Standards Subcommittee to tackle, but a problem that deserves high-level consideration is the prospect our domestic coding industry could move off-shore. During Y2K, domestic programming resources were insufficient to meet

The second concern the Education and Coding Workgroup had was about the readiness of our clinical documentation, especially procedure documentation, to support the needs of ICD-10. Surgical operative reports and interventional procedure reports were not providing sufficient detail to match documentation with the new ICD-10-PCS procedure codes.

By delaying implementation, Congress provided welcomed breathing room.

2. **What is the impact of the new delay on the calculation of Medical Loss Ratio?**

   Response: Since we are not in the medical insurance business, this does not directly impact BIDMC. As I understand it, a percentage of ICD-10 transition expense can be counted as quality improvement for 2012 and 2013. The balance must be considered administrative overhead and subject to the overhead cap that was enacted as part of the Affordable Care Act.

   Although not an insurer, it is hard to understand the logic of capping administrative overhead on one hand and mandating a program like ICD-10 on the other. If insurance company experience is the same as ours, their ICD-10 transition costs are probably much higher than predicted and the bulk of them are "recurring" meaning they go on forever.

3. **What are the cost implications of the delay in implementing ICD-10?**

   Response: While there are sunk costs, delaying ICD-10 allows BIDMC to defer some recurring costs and devote more time to improving clinical documentation so that it is compatible with ICD-10; especially ICD-10-PCS.

"The more significant costs associated with ICD-10 are not one-time. The more significant costs are recurring and go on forever."

To date, we have spent approximately $2.4M on ICD-10. This is largely one-time expenses for consultants, software remediation, training and education. There have also been thousands of hours in staff time devoted to various project meetings and work sessions related to ICD-10 that are not directly charged to ICD-10 project costs.

Yet, the more significant costs associated with ICD-10 are not one-time. The more significant costs are recurring and go on forever. These costs are for added coding and coding validation staff, software license subscriptions, software maintenance, training and education.

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the demand for software remediation. Firms looked to India and other off-shore locations for this assistance. The efforts were successful and many software development jobs never returned to the USA once the urgency of Y2K passed.

The situation could easily repeat itself because of the demand ICD-10 has created for experienced coders. Off-shore coding labor rates are a fraction of domestic rates. With pressure on healthcare providers to reduce expenses, there is a genuine threat that we could see more coding jobs lost to off-shore operations when the transition to ICD-10 occurs.

We expect the recurring expense for ICD-10 to be approximately $3,270,000 per year or $16,350,000 over a five year period. This does not include the extra time it will take our clinicians to document to ICD-10 standards.

4. **What contingency plans are being developed by organizations that planned to implement ICD-10 October 1, 2014?**

   Response: We will complete end-to-end testing to include simulated transactions with our major payers. In Massachusetts we opted to join together with other providers and payers and collectively contract with a testing firm. The contract does not allow for a "pause" button so we will complete the testing as scheduled before September 30, 2014.

   Dual coding of ICD-9 and ICD-10, planned to occur between April and September 2014, will be scaled back to minimal levels needed to retain some coder knowledge of ICD-10. The "freed-up" coder time will allow us to re-focus on documentation improvement, coding throughput, coding validation, and other areas that had been deferred or scaled back in lieu of ICD-10 transition priorities.

   Mid-2015, we will ramp up our dual coding efforts and repeat whatever testing is needed to adjust for standards, technology and workflow changes occurring between now and then.

5. **Would there be any benefit in allowing ICD-9 and ICD-10 to be used concurrently prior to the full implementation of ICD-10?**

   Response: As mentioned above, we will continue to train and dual code a modest number of cases in ICD-9 and ICD-10 to keep the "pilot light lit". Beyond that, there is no benefit to allowing both ICD-9 and ICD-10 for claims submission prior to the reset date. In fact, it would likely result in a more complex, confusing and costly workflow.

6. **What are the most important areas and opportunities to focus on during the delay period?**

   Response: Had October 1, 2014 remained as the transition date, I do not believe the clinical procedure documentation or the number of experienced coders would have been adequate to support ICD-10 coding.

   Insofar as experienced coders, we anticipation of a "productivity hit" with ICD-10. Predictions were that we would experience a 50 percent reduction in productivity. In response, we increased the budget for coding and coding validation staff from 17.37 to 31.2 FTE. The market for experienced coders was heating up because of ICD-10 and general demand increases coming from auditing and other firms. In the past twelve months, for example, we suffered the loss of six of our most experienced coders.

   We also witnessed the defection of some contract coding resources to other customers who would pay more.

   In an effort to ensure we had sufficient coding and coding validation staff, we started two in-house training programs. One, called the "Pipeline" program, retrained mid-career staff who

wished to change occupations. The other, called the "Bridge" program, identified coding school students and graduates who needed a practicum before they could be hired.

Both programs have been successful in producing added coding staff, but graduates require months of seasoning before they can code more complex cases. The delay to October 1, 2015 allows this to occur.

ICD-10-CM has been used for years in other parts of the world and has, therefore, underwent a long "shakeout cruise" prior to its introduction to the U.S. This is not the case with ICD-10-PCS. It is my understanding the field trial for ICD-10-PCS was quite limited and done using a selective group of volunteers. The design is elegant, but some of our most highly respected surgeons and proceduralists find some codes difficult to interpret. The terms used to define them have fine distinctions and explanatory references are not always available.

In some instances, our HIM staff has written CMS for clarification, but the response time has been slow. We suspect the fact that ICD-10-PCS has yet to be "battle hardened" may be contributing to a large influx of such inquiries to CMS.

The gulf between clinical documentation and ICD-10-PCS will require our coding staff to send many queries to physicians asking them to clarify documentation. Our coders and physicians would be inundated with back-and-forth communications to clarify the specific procedures performed in the parlance of ICD-10-PCS. This would have further reduced coder efficiency and led to claim filing delays. For queries not answered, coders would need to default to less specific codes for ICD-10-CM. For ICD-10-PCS, coders would be stymied and not able to complete the code without the specific data point/clarification available.

The delay gives time to improve our clinical documentation and mature the coding workforce.[2]

A third area upon which we will focus is implementing an electronic version of our fee ticket. Annually, HIM assigns about 742,000 ICD-9 diagnostic and 182,000 procedure codes. Another 1,400,000~ ICD-9 diagnostic codes are assigned by ambulatory service providers by checking-off codes on paper fee tickets.

The typical fee ticket has ICD codes on one side and CPT-4 codes on the other. The ICD-10-CM code set expands choices to the point they can no longer be represented on a single page. For that reason, our clinical application team has developed an electronic version of the fee ticket. The ICD-10 reset date will provide time for us to roll-out this application at a pace that is consistent with good change control.

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[2] Of note, our medical center uses about 8,700 unique ICD-9 diagnostic codes and 1,800 unique ICD-9 procedure codes today. About 80 percent of the diagnostic codes are 1:1 mapping to the new ICD-10-CM codes. With procedures the mappings produce far more ICD-10-PCS options per ICD-9 procedure code. Over 60 percent of the ICD-9 procedure codes we use today map to 3 or more ICD-10-PCS choices.

Although ICD diagnostic codes increased four-fold in ICD-10-CM, 65 percent of the increase is due to laterality and expansion of "external cause" related codes for injuries, poisoning and the like. Given the negative reaction we are seeing among the clinical providers and media attention given to the more exotic accident codes, it is questionable how often the "external cause" codes will be used.

7. Should the new deadline be 2015 or beyond 2015?

Response: This is a complex question. ICD-10 will increase the percentage of our budget that is spent on administrative overhead. It will add to the complexity of the clinical documentation, coding, and claims reimbursement process. These seem contrary to the intent of "administrative simplification" so whenever ICD-10 is introduced, it will not be welcomed.

"Promoting ICD for disease classification and deprecating it for reimbursement should be considered. … The tie between reimbursement and ICD codes makes the conversion much more complicated."

ICD diagnostic codes serve an important, world-wide role in classifying diseases. Using them as a basis for reimbursement, as is done in this country, creates problems. ICD-10-PCS, which is unique to the U.S., makes matters worse. It is this extended use that drives the complexity of the ICD-10 project.

The tie between reimbursement and ICD-10 codes makes the conversion much more complicated. Adding a new procedure set with ICD-10-PCS makes it even more complicated. Far more software applications, workflows, documents, policies, and staff become involved where there are reimbursement dependencies.

The following statement may seem like swimming upstream given the groups who benefit from status quo. Promoting ICD-10 for disease classification and deprecating it for reimbursement should be considered.

"Many terms and definitions supporting ICD codes are not part of the medical language of physicians. This is especially true of ICD-10-PCS."

Many terms and definitions supporting ICD codes, especially those used in ICD-10-PCS, are not part of the conversational language of physicians. This is especially true of ICD-10-PCS. Translating clinical documentation into codes is a very subtle and nuanced process. Even among experienced coders, translating documentation to codes can result in different outcomes. This is particularly true if the conventions and definitions are not available to providers, payers and others who use the code set.

Basing medical reimbursement on ICD codes (and CPT codes) has led to the creation of an industry within an industry. Sophisticated coding, grouping, and edit checking software are needed. At BIDMC, we pay more than $500,000 per year on commercial software subscriptions made necessary because codes are connected with reimbursement. Specialized compliance staff must be hired to oversee the process. Consultants, who are experts in coding improvement, are frequently hired. The list goes on and on.

The introduction of present-on-admission, hospital acquired condition, patient safety indicators, and other ICD-10 code-dependencies cause more difficulties. For example, the effort and expertise needed to translate documentation into codes for some of the patient safety indicator (PSI) related codes can be especially challenging. This is observable in the dramatic drop in "numerator-related" codes since PSI's were introduced among some medical centers.

The subtly required to translate clinical documentation into codes opens the door for interpretative differences. Providers tend to interpret in their favor. Payer auditors tend to interpret in their favor. This results in an ever increasing administrative cost burden for audits, denials, and appeals.

Placing ICD-10-PCS into service is more challenging than ICD-10-CM. About 80 percent of the ICD-9 codes used today at BIDMC can be mapped, 1:1, to a counterpart ICD-10 code. ICD-10-PCS is not so easy. Over half the ICD-9 procedure codes map to 5 or more ICD-10-PCS codes. Might it be possible to implement ICD-10-CM in October 1, 2015, but hold on implementing ICD-10-PCS? Should CPT-4 be reconsidered for both inpatient and outpatient procedures as a "good enough" procedure code set? Alternatively, could a unifying procedure set be developed that is not as complex as ICD-10-PCS? We realize these have pro's and con's, but what is now being done is not promoting administrative simplification. It would make sense to have one procedural system that was uniform, transparent, meaningful, and promotes administrative simplification.

If provider-side administrative costs are truly to be reduced, we need to reconsider how ICD-10 and CPT codes are used in reimbursement.

8. **What are the implications of the delay for providers implementing Meaningful Use?**

   Response: BIDMC has a long history of in-house developed EHR. For the past several months, our clinical application development staff spent much of their time preparing for Meaningful Use, Stage II certification. This prevented them from spending time on electronic documentation improvement that would better prepare BIDMC for ICD-10.

   When Congress delayed ICD-10, it caused a sigh of relief. Our development staff successfully achieved Stage II certification and can devote more time between now and October 1, 2015 to clinical documentation improvement.

9. **What is the impact of using diagnostic codes (ICD-9 or ICD-10) in Meaningful Use?**

   Response: None as far as we are aware. Meaningful Use seems to focus more on clinically relevant vocabularies like SNOMED-CT, LOINC, and others. The ICD-10 project work did collide with the work related to Meaningful Use insofar as competing for the same staff resources. Several of our clinical application development staff members were supporting both initiatives which stretched them thin.

10. **What are the implications of the ICD-10 delay on business operations, systems, and financial resources?**

Response: The implications of the delay are generally positive for the reasons previously described.

At least from my viewpoint, ICD-10 has few supporters among practicing clinicians. BIDMC has over 2,500 physicians on staff and I've yet to encounter one who believes ICD-10 will benefit them or their patients. To the contrary, ICD-10 is viewed by them as a distraction and necessary only to satisfy reimbursement requirements.

They view the language of ICD coding as arcane and not the colloquial language of clinicians.

The benefits case offered by proponents of ICD-10 did little to help offset this view. The benefits case was vague and not provider focused. At "ground-level" in the medical center, the only consequence that can be seen by ICD-10's introduction is more administrative overhead.

The $3.3m~ in marginal, recurring expenses that will be added as a direct result of ICD-10 will come from other parts of the medical center. This includes direct-care and ancillary care support staff.

Unfortunately, it is hard to see how ICD-10 is promoting "administrative simplification" at ground-level.

11. **What must be done to ensure no further delay?**

    Response: Consider implementing ICD-10-CM only, deferring ICD-10-PCS and unifying all procedure coding around CPT-4 (or another unified procedural coding system), and reducing the dependency on medical reimbursement to ICD codes.

    Achieving true "administrative simplification" cannot be done by making things more complicated and costly.

In summary, I encourage the Standards Subcommittee to pause and examine the impact ICD-10 will have on administration simplification. This requires a willingness to absorb significant "headwinds" as the momentum is clearly in the direction of implementing ICD-10-CM/PCS. If the Standards Subcommittee wishes to promote administrative simplification, continuing on the current course will not do it; at least from the view of our medical center.

The Standards Subcommittee should focus on initiatives designed to increase the percent of clinician time available for care delivery and decrease the percentage of provider budget required for administrative overhead.

I thank Subcommittee for the opportunity to submit this testimony for the record.

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