Commentary: The ICD-10 Saga—Lost Years and Hard Lessons

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By Rich Averill

The August issue of the *Journal of AHIMA* features an article by Sue Bowman that chronicles the dire predictions of negative consequences that would ensue if the antiquated 30-year-old ICD-9-CM coding system was replaced with the modern and up-to-date ICD-10 coding system. This routine administrative update became such a highly charged political issue that Congressional hearings were held with demands for Congressional action to stop ICD-10. In the end, it took 20 years and three delays before ICD-10 was implemented.

As Bowman observes in "A Look Back on the ICD-10 Transition: Crisis Averted or Imaginary?", the transition to ICD-10 has largely turned out to be a Y2K-like non-event with none of the dire predictions actually occurring. She appropriately asks whether ICD-10 implementation was a crisis averted, a crisis that was imagined, or a crisis that was intentionally fabricated. Any major change to the basic healthcare data infrastructure will have stakeholders motivated by their own special interests.

If the transition to ICD-10 is any indication of the course of future updates to our basic healthcare data infrastructure, it is important to understand the tactics and motivation behind the policy debate and the campaign to stop ICD-10 implementation.

Proponents tended to argue the merits of ICD-10 with an academic approach that focused on healthcare policy. They made their case in scholarly journals that reached like-minded readers and not necessarily mainstream audiences. Proponents cited objective evaluations such as an exhaustive 2004 RAND study analyzing the cost benefit of ICD-10 implementation, but they initially failed to communicate and promote the value of ICD-10 in a way that ensured all healthcare industry participants understood its importance.

Opponents of ICD-10 took a different approach, one that was more like a political campaign with unrelenting sound bites of misinformation that sought to alarm and create opposition among key policy and Congressional leaders. As documented by Bowman, opponents said there were "too many ICD-10 codes," which would be impossible to learn and use. The new codes would create havoc with the claims process and cause increased claims denials, cash flow disruptions and revenue shortfalls. The expense of implementing ICD-10 would put small physician practices out of business, they warned, and for those practices that survived ICD-10 would be so burdensome that patient care would suffer.

Hospitals also would be negatively impacted, opponents claimed. They predicted a huge drop in coder productivity, which would lead to slowdowns in payment that would cause major business disruption. Finally, opponents said the Centers for Medicare and Medicaid Services (CMS) wouldn't be ready by the implementation date, nor would payers. "The healthcare industry needs more time," was their message to Congress, an argument repeated time and again over two decades.

While ICD-10 proponents focused on the policy issues, opponents issued grim warnings, designed to earn media attention in today's fast-paced news cycle. Unsubstantiated by independent research and analysis, their warnings were reported across US media with virtually no investigation or fact checking. With few exceptions, even healthcare industry journalists avoided any in-depth evaluation of the case against ICD-10. Instead, publications featured stories about "ridiculous" ICD-10 codes, which presumably attracted readership and drove increased traffic to media websites. Biased opinions with no factual foundation were portrayed as undisputed truths.

The existence of ICD-10 codes for an alligator bite or being pecked by a turkey, for example, were continually held up as laughable and an example of the government demanding overwhelming detail and creating a huge burden for providers. This ignored the fact that similar codes have always existed without causing a burden, that such codes are not generally required to be reported except for infrequent situations such as a worker compensation claim, and most important, that the codes could become essential from a public health perspective given the risk of animal-to-human disease transmission (i.e., swine flu, avian flu, etc.)

At the outset, proponents of ICD-10 mistakenly believed that all healthcare industry stakeholders would view ICD-10 as a necessary administrative update to the US coding system, not dissimilar to a routine software update. Most other industrialized countries had implemented ICD-10 a decade earlier without issues, and it was assumed the US would follow a similar path. The intensity of opposition caught proponents off-guard and they were unprepared with an effective response. ICD-10 opponents had set the tone and it was difficult to undo the misinformation.

It was not until the third ICD-10 delay that the Coalition for ICD-10 (made up of AHIMA, AHA, HFMA, AHIP, National Blue Cross Blue Shield, and other organizations) began addressing negative messaging with more confrontational rebuttals along with aggressive outreach to the press. The result was more balanced media reporting.

Still missing from the debate, however, was any examination of motive. Among the industry groups and stakeholders that opposed ICD-10 were strong advocates of SNOMED. Their published opposition to ICD-10 was never evaluated in the context of their support for SNOMED.

Unlike other countries, the US uses different procedure coding systems for inpatient and outpatient care. Prior to ICD-10 implementation, existing procedure coding systems were loosely organized lists of unstructured codes with no terminology definitions, while the ICD-10 procedure codes are a modern, multi-axial seven-character system with clearly defined terminology. The contrast is so stark that the healthcare industry may eventually question the necessity of multiple procedure coding systems, potentially jeopardizing the continued use of separate systems for inpatient and outpatient care.

Was ICD-10 viewed as a threat to the continued use of two procedure coding systems, and was this a factor in galvanizing opposition to ICD-10? Again, motive was never explored in any media reporting and ICD-10 proponents were unwilling to raise the uncomfortable question of whether unspoken special interests were behind the opposition to ICD-10.

In the years ahead, the healthcare industry will continue to move forward with standardization of our basic healthcare data infrastructure, making sharing, interpreting, and interoperability of healthcare data more effective. Based on the ICD-10 experience, future infrastructure updates and policy changes may encounter similar aggressive opposition. The lessons from ICD-10 are clear. Proponents must clearly define and communicate the purpose and value of the change for all healthcare stakeholders. They must prevent opponents from owning the story and message. An aggressive public relations effort should be launched at the outset, with education and information that reaches healthcare audiences in a way that's easily accessed and understood. Any misinformation should be quickly refuted. The public policy debate also requires a full understanding of the motives of all stakeholders and any potential conflicts of interest.

The transition to ICD-10 has turned out to be a relatively smooth process. None of the dire predictions have come true and the healthcare industry is ready to move on. Before we relegate the implementation of ICD-10 to history, however, policy makers should evaluate the credibility of ICD-10 opponents, especially as it relates to the debate on future healthcare data infrastructure changes.

Put simply, how could ICD-10 opponents have been so wrong? Even more important, how were the opponents of ICD-10 able to convince the media and members of Congress to accept their unfounded claims without anyone successfully discrediting them? There is much to learn from the ICD-10 experience. Someday, we may view the long and arduous road to ICD-10 as an anomaly that will never be repeated. If future policy debates become as contentious, however, proponents of change need to understand the lessons of the 20-year ICD-10 saga.

Richard F. Averill is principal at The Hesperium Group, and recently retired as senior vice president of clinical and economic research at 3M Health Information Systems.

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