ICD-10 Debunked and Confirmed: Learning about ICD-10 from the Past, and the North

By Doris Gemmell, BSc MBA, CHIM

Seven ICD-10 Myths Confusing Healthcare Today, and the Canadian-Proven Reality

---

Heads up: ICD-10 is coming. Actually... heads "north."

American healthcare providers curious about how the pending ICD-10 implementation will impact their processes need only to look to the north for guidance. Canadian experience with ICD-10-the country began implementing a version of the code set in 2001-can provide significant insight for health information management (HIM) professionals in the United States.

Across the country, several of AHIMA's component state association (CSA) meetings have included educational sessions describing the ICD-10 strategies implemented and lessons learned from Canada. As HIM directors in the US take a deep breath and once again move facility efforts toward the now-finalized ICD-10 implementation deadline of October 1, 2014, the time is right to soak in the wisdom offered by the Canadian experience.

Change can be scary, and that fear can breed misinformation. There are no shortage of myths surrounding the impact ICD-10 will have on healthcare providers and the industry as a whole. But the only way to figure out if a myth can be trusted is by examining cold hard facts gleaned from firsthand experience. For ICD-10, that experience comes from the "Great White North."

Based on experience gained from the Canadian implementation of the code set, seven common ICD-10-CM myths involving the breadth, timing, translation, technology, and outcomes of the transition from ICD-9 to ICD-10-CM are debunked or confirmed and explained below. Specific tips on helping affiliated physician groups and practices get up to speed with ICD-10-CM are also included, with the goal of replacing incorrect rhetoric with actionable insight.

Myth #1: ICD-10 is Only a Coding Issue

FALSE. The effects of ICD-10 are far-reaching and go well beyond the coding function. Processes upstream and downstream of coding within a healthcare provider's organization are impacted by ICD-10. HIM directors should identify every process in their facility that relies on clinical codes. All of these functions must be evaluated and rolled into ICD-10 planning. The list will be long, but includes at a minimum the following key stakeholders and workflows:

- **Physician and clinical documentation.** These areas need more documentation specificity and will be affected by the need to include information about a patient's significant co-morbid conditions.
- **Computer systems and interfaces.** HIM staff should review with stakeholders the areas where ICD-9 codes will require replacement to help ensure an accurate, seamless flow of codes.
- **IT personnel.** This group must be included in ICD-10 education to assure IT handshakes between systems still occur and continue to support current processes.
- **Finance.** This group needs to understand the impact ICD-10 has on revenue, whether positive or negative, and develop a mitigation plan. Differences between ICD-9 and ICD-10 will drive DRG and reimbursement changes. For example, cholecystectomy procedures can be reimbursed in dramatically different ways depending on the coded surgical option-open, closed, robotic, laser, etc. This specificity wasn't available in ICD-9. Many diagnoses and procedures will be impacted from a revenue perspective.
- **HIM.** The entire department will be impacted, not just coders.

- **Executive leadership.** There will be additional opportunities to analyze data based on an entire argosy of new, specific information that can be used for improving patient outcomes, financial fitness, and anything else that relates to patient care and creating a foundation for healthcare improvement.

Myth #2: Skipping Ahead to ICD-11 is a Viable Option

FALSE. Having been through the transition and working with ICD-10 for nearly a decade, Canadian healthcare professionals cannot imagine skipping ICD-10 in order to leap to ICD-11. ICD-10 is a precursor to ICD-11; a necessary stepping stone. It would be very difficult to migrate to ICD-11 if the US healthcare industry did not take the proper step to ICD-10. Most US providers and vendors have already invested a great deal of time and energy in preparing for ICD-10-an investment that would be wasted if providers were told to start from scratch with ICD-11.

And since ICD-11 is still being developed, another 20 years could pass before it is fully ready to implement in the US. The nation's current coding system, ICD-9, simply cannot support the complex and technologically advanced US healthcare system any longer. If forced to wait for ICD-11, providers would sadly miss out on all the granularity benefits of the more specific and up-to-date code set for another two decades.

Myth #3: GEMS Solve all Translation Issues

FALSE. In the Canadian experience, general equivalence mappings (GEMs) were used in some coding software to make the ICD-9 to ICD-10 transition easier for coders. GEMs provide a mapped link between ICD-9 codes to ICD-10 codes. But after a few months of use, it became obvious that the difficulties created by using these GEM "shortcuts" made the ICD-10 learning curve longer. Not only that-the mappings were simply not adequate.

Coders were still relying on old ICD-9 codes and counting on the GEMs to do the translation work for them, rather than diving in and fully embracing the new framework of ICD-10 coding architecture. Though GEMs may be necessary in the US environment while all stakeholders get on board with ICD-10, they are not a long-term solution.

Between ICD-9 and ICD-10 there are very few one-to-one translations. GEMs are simply a translation book that should be used when coders are stuck. US providers must let go of the translation book and get on with the task of learning the new language. Efforts spent incorporating GEMs are better used actually learning ICD-10.

Myth #4: CAC Mitgates Productivity Losses

TRUE and FALSE. In time it is expected that computer-assisted coding (CAC) will provide benefits to coding in much the same way voice recognition software changed medical transcription. Many facilities have found that CAC is a great tool that delivers value in its ability to analyze charts and provide a complete set of possible codes. The emerging technology holds great promise for improving coding functionality over the next decade.

However, human coders continue to be the final authority in Canada, and will remain so in the US for some time. Coders make the final decision with regard to code assignment and DRG, even at a facility using state-of-the-art CAC. Coder productivity will improve with use of the software, but any lofty vendor estimations on production should be seen as suspect.

CAC systems are only as good as the clinical documentation that is fed into them. If clinical documentation remains non-specific and incomplete, a CAC system is of little value to the healthcare organization. Finally CAC products are expensive to implement and many hospitals, especially small- to medium-size facilities, may not be technologically or financially prepared to use CAC.

Myth #5: Patient Outcomes Improve with ICD-10

TRUE. Patient outcomes do improve with ICD-10. This is primarily because the new system reduces the need for the use of "unspecified" or "not elsewhere classified" codes. Granular coding drives more specific data that clinicians can use to support targeted clinical decision making.

In Canada, HIM professionals found that clinicians armed with analytics tools that used rich ICD-10 data brought tremendous value to patient care delivery. HIM professionals must fine-tune their data analytics skills and employ new resources to mine this data and make the most of the new coding system. Providers can actively look at a wide range of clinical indicators when treating a patient, down to a very specific disease or procedure (i.e., mortality, length of stay, readmission).

Canada has made great inroads in improving patient care through the use of ICD-10 coding. Diabetes, acute myocardial infarction treatment, and injury prevention are three examples where the specificity of codes has been used to the patient's advantage. You need only to take a tour through the Canadian Institute for Health Information's website, www.cihi.ca, to see how enhanced ICD-10 coding can be used to improve health outcomes.

A specific example of this improvement comes from the Regional Health Authority in northern Canada, who was alarmed by the high number of accidents prompting visits to the emergency department. They used ICD-10 accident codes to determine their "top 10" accidents for the region. Using this information, the health authority and medical communities developed action plans to raise awareness and promote accident prevention that was focused on the top problems.

Myth #6: ICD-10 Will Not Benefit Physicians

FALSE. While ICD-10 implementation can cause headaches for physicians, there is a wealth of information that comes from the more specific code set that will ultimately benefit their patients' healthcare outcomes. It will certainly take time and energy for physician groups to make the change, and Canadian providers found that ICD-10 is not a quick fix, However, if physicians are truly motivated to improve healthcare, ICD-10 is a valuable and proven tool.

Benefits of ICD-10 for physician groups include:

- The addition of laterality to the code set can smooth the reimbursement process. For example, a patient injures their right hand one week and their left hand the following week. Without laterality, payers may think a provider is submitting two consecutive claims for treatment of the same patient injury. But ICD-10 codes provide enough specificity in laterality (right hand and left hand) for payers to understand what has actually occurred. This will result in fewer denials, queries, and lost revenue.
- The code set can be used to determine the efficacy of certain standard procedures. For example, it can be used to study if open surgery is better than laser, robotics, or laparoscopy. ICD-10 can provide specific information on these types of surgery, as well as on adverse effects from medication errors, surgical errors, falls, etc. This information can be used by physicians to improve quality of care and future patient outcomes.
- The ability to track socioeconomic conditions such as homelessness, drug use, and morbid obesity is another benefit of the ICD-10 code set. These factors greatly affect patient outcomes and treatment costs in group settings when the information is analyzed and used.

There is no magic pill that will make the change to ICD-10 pain free for physician practices and groups. But there is not currently another code set that is easier or better to use at this time. As seen in Canada, ICD-10 provides a pathway to improved patient care.

Myth #7: ICD-10 is Worth the Hard Work

TRUE. Listen to the Canadians who have been through the process, and they will say the move to ICD-10 is worth the trouble. The number of data analysis reports US providers will soon be able to create and the volume of new insights clinicians will gain with ICD-10 are unimaginable and vast. But the full benefits of ICD-10 are only realized when providers make the most of new data mining and analytics capabilities.

Ten years post-implementation, many hospitals in Canada have established decision support departments that help maximize their return on investment in ICD-10. Quality data and decision support analyst teams within HIM departments are common. These teams enable medical researchers using ICD-10 codes to leverage analytic support and make evidence-based clinical decision-making a reality.

There are challenges that come with ICD-10 as well. Some coders and areas of coding will continue to face problems and confusion months or years after ICD-10 is implemented. For example, diabetes coding and documentation in ICD-10 still

perplex many Canadian coders and physicians, leading to expanded educational needs in this area.

While it is true the Canadian single payer healthcare reimbursement system is different from the US, many of the coding challenges and successes that come with ICD-10 will remain the same. The fear of change is a constant for any country implementing a brand new code set. US HIM professionals should be encouraged to reach out to their Canadian counterparts for insight and guidance on ICD-10. Many Canadians would be open to help inform and guide US coders through the ICD-10 journey.

Doris Gemmell (dgemmell@accentusinc.com) is director of coding services at Accentus Inc,, based in Ottawa, Ontario, Canada with offices in Waukegan, IL and Bonita Springs, FL.

Article citation:
Gemmell, Doris. "ICD-10 Debunked and Confirmed: Learning about ICD-10 from the Past, and the North" *Journal of AHIMA* 83, no.11 (November 2012): 34-37.