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ICD-10 – It's Here; What Does it Mean and Why does it matter?
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October 1, 2015, the entire healthcare industry is changing the coding system for the healthcare industry to a "new" system entitled, **ICD-10**, which is how diagnoses are documented in medical records and which is used for billing insurance companies such as Medicare and Medicaid for the services patients receive.

The transition to ICD-10 has been scheduled and delayed multiple times in the past fifteen years because of the cost and complexity of the process. Other countries have been using ICD-10 since 1995 when it was first published. In addition, ICD-11 should be ready in 2019. Most experts think that transitioning from ICD-9 to ICD-11 would be more complicated than going from ICD-9 to ICD-10 and then a several years later doing ICD-11.

There may be significant disruption in the healthcare system due to this transition but none of the potential problems should affect patients. The greatest risk is to health providers who may not be ready for the transition, making it difficult for them to collect their fees.
SETMA has been working on the transitions for two years and anticipates no problems.

At 10 PM on September 30th, SETMA's EMR will be "shut down" and the entire system will be switched to ICD-10. At 1 AM, October 1st, the EMR will re-launch and all coding, documentation, billing and services will be done with ICD-10, in the clinic and in the hospital. This seemingly easy transition, which will be done in two or three hours, is possible because of thousands of hours of work. The majority of the work has been done by a few, but hundreds have been involved. The cost of this project is impossible to know exactly but it clearly approaches one million dollars.

The transition of our system to ICD-10 has been tested and re-tested dozens of times. SETMA's Central Billing Office has tested interfaces with insurance companies and clearing houses to affirm that everything is working perfectly. SETMA providers have been training on ICD-10. Five years ago, SETMA switched to a coding system which has 100,000 codes, to prepare for the complexity of selecting diagnoses from a list of 150,000.

We expect the transition to be seamless and smooth. The details of this process are interesting and may be told in the future. It has been complex, time consuming and expensive, but we are ready.

ICD History

ICD-9 stands for **International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9)** and has been in use since 1979. However, the system was never intended to be used for documenting diagnoses in an electronic record system.

The current International Classification of Diseases (ICD) can trace its roots back to the Bertillon Classification first published in 1893. Starting in 1900, experts met about every 10 years under the auspices of the French government to revise the classifications. The fifth revision (ICD-5) was published just before World War II. The World Health Organization took over responsibility for ICD in 1946 with publication of ICD-6. The intended purpose of the 1979 ICD-9 diagnosis codes is for statistical tracking of diseases. (Nothing more) Codes are added only when it can be demonstrated that it will help in the identification and monitoring of the disease.

ICD-10

The mandate for ICD-10 was a part of the 1996 Health Insurance Portability and Accountability Act (HIPPA). The ICD-9 code systems consisted of about 15,000 codes; the ICD-10 system will consist of almost 150,000 codes. Without electronic medical records the value of the ICD-10 system will be difficult to realize. Why the mandate for the change?

As stated earlier, the ICD-9 coding system was never intended to be used for documentation of diagnoses in a patient's medical record. It was a statistical system for public health and it was adopted by insurance companies for payment purposes. For instance, if a patient had elevated magnesium, there was a code which could be sent to the payer to warrant payment for performance of a magnesium level. The same was true for a patient that had a low magnesium level. The problem in ICD-9, was that the high and low magnesium had the same code. For payment purposes that was OK, but for documenting a medical record, electronically, with the ICD-9 coding system, it was difficult. And, clinically, in a medical record, there was a critical difference between low and elevated magnesium. And, in that medical records are often the way healthcare providers or organizations communicate with one another, it was critical for patient safety.

The same complexity and obtuseness of the ICD-9 coding system existed when it was important to know whether a condition was on the right or left side of the body. This is called "lateralization." If your right ankle is broken; it is important to document that rather than just to document "fractured ankle." Obviously, if you were hand writing diagnoses or dictating diagnoses, it was simple to write or say, "Right ankle." But, if you are using an electronic record, where you want to "select" the accurate and specific diagnosis or when sending a charge to an insurance company, electronically, the same deficiency existed. ICD-9 provided no structured, systemic way to clarify the "right," "left" distinction. ICD-10 does.

Another key deficiency of ICD-9 was its inability to designate the "episode of care." For instance, when you diagnose a patient with a myocardial infarction, it was important for payment, documentation and research to know if the episode of care was the first or subsequent. ICD-9 could not make this distinction by code, ICD-10 can.

Also, if you have ever looked at an ICD-9 code book, you will see how confusing it can be. Due to space issues in electronic systems, many abbreviations had to be used in creating the ICD-9 system. Many of those abbreviations are not easy to understand. New systems have been created to allow for more intuitive descriptions of conditions but even the ICD-10 systems is not as good as it could be. As a result, one to three years after switching to ICD-10, healthcare providers are required to adopt SNOMED.

SNOMED was started in 1965. It stands for Systematized Nomenclature of Medicine – Clinical Terms. The greatest benefit of ICD-10 will be the adoption of SNOMED. At last, electronic record documentation will be an active and important part of excellence in patient care. In ICD-9 and in ICD-10, there are codes for designating that a patient "lives alone". Few things in efficient and excellent patient management are as important as knowing that a patient "lives alone". However, this designation is incomplete. Before her death at 97.5 years, my mother lived alone, but she had almost hourly contact with friends, family, neighbors, church members and others who watched out for her and who helped with her daily needs. "Living alone" was not a healthcare risk or complication for her. So, while it is important to document in the hospital and in the ambulatory setting that a patient "lives alone", it does not let the healthcare team know the "real" needs of the patient. With SNOMED, the code for "lives alone" has a more precise description which is "lives alone, no help available." The benefit of this more granular code description is obvious.

STEPS to ICD-10

The greatest difficulty in switching to ICD-10 was the mapping of ICD-9 code numbers to ICD-10 code numbers. Where the description of the ICD-9 code was the same as the ICD-10 number it was simple. But many times the computer could not recognize the ICD-9 description as matching an ICD-10 description. Because of SETMA's use of disease management tools, clinical decision support and other electronic tools, the majority of the mapping of ICD-9 codes to ICD-10 codes (586,000 entries) was done through automation. However, when the automation wad done, there were still 67,000 codes in SETMA's data base which could not be changed into an ICD-10 code automatically. Therefore, in 2014, all SETMA providers began manually mapping ICD-9 codes with ICD-10 codes with patients they were seeing while other SETMA staff took lists of patients' names and mapped their codes manually.

Because we did our work well, as of March, 2015, all of the mapping was done. Each day an electronic report is completed of patients who have codes which have not been matched. This results from patients being seen, who have not been seen in seven years. Generally there is one or two a day. As a result of this effort, when SETMA switches to ICD-10, it will be easy and automatic. Because SNOMED follows upon the heels of ICD-10, and because all diagnoses have been mapped to ICD-10, SNOMED has already been completed in SETMA's EMR. In 2019 or 2020, when ICD-11 is released and required to be used, it will be mapped automatically

to ICD-10 making the conversion to ICD-11 as simple and as automatic as was the conversion to SNOMED.

Why is this important to you?

If you healthcare provider does not successfully navigate to ICD-10, he or she will not be able to capture the charges for the services performed and they will not be able to submit bills and receive payments for those services. Your might ask, “Why should I care; after all aren’t healthcare providers over paid anyway?” You will discover how much you care, if because your healthcare provider cannot charge, bill and collect fees; he or she closes his or her office and is no longer available to work with you to maintain your health or to treat your illness. This is only a potential risk but it is a risk which should concern you.