Coburn Amendment 1010 - To prohibit HHS from implementing costly and burdensome coding standards (ICD-10) as required under current law.

This amendment would prohibit the Secretary of Health and Human Services (HHS) replacing the International Classification of Diseases, code version nine (IDC-9), with the tenth version (ICD-10), in implementing code set standards in accordance with the Health Insurance Portability and Accountability Act of 1996.[1]

The main difference between the current ICD-9 and the new ICD-10 system is the sheer volume of codes. ICD-9 currently has approximately 18,000 codes while ICD-10 uses approximately 140,000 codes.

Most of the increased number of codes is attributable to excessive details, not the unearthing of new diseases or clinically-necessary information.

While the desire to adopt these codes may be well-intentioned, adopting the codes (1) will increase health care costs, (2) will burden providers and (3) does not directly improve patient care or outcomes.

Adopting the Codes Will Increase Health System Costs

Estimates regarding the additional costs of the implementation of ICD-10 have varied, but all estimates show significant additional costs to the system.

- One study from the American Medical Association, the Medical Group Management Association, and others has pegged the adoption costs for a small practice at $83,000, ranging up to $2.7 M for a typical large practice.[2]

- Ernst & Young has noted that HHS pegs the cost of the coding conversion at $1.6 billion, but "costs won't even break even until 2018."[3]

- A September 2010 estimate from the Association of Health Insurance Plans estimated "total system-wide cost" *just for health insurance companies* could be as high as $3 billion.

- One industry survey found that the top cost-related concerns for adopting ICD-10 are "updating relevant IT systems, training staff, increased documentation, replacing antiquated IT systems, and hiring new employees."[4]

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[1] http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/icd10
[2] http://www.mgma.com/press/default.aspx?id=22586
[3] http://www.ey.com/GL/en/Services/Advisory/ICD-10_code_How-much-is-this-going-to-cost-
[4] http://www.icd10watch.com/blog/readers-respond-top-5-icd-10-cost-concerns

All of this heads the wrong direction. We should be reducing, not increasing, health system costs.

Adopting the Codes Will Burden Providers

The implementation of ICD-10 will be particularly burdensome on practicing physicians, who will be required to focus on billing, rather than patient care.

- Under current law, physicians face a number of looming penalties and payment reductions under Medicare's PQRS initiative, Electronic Prescribing (eRx) program, and EHR program (see chart).[5]

- Additionally, physicians face a number of systemic changes and challenges related to implementation of the Patient Protection and Affordable Care Act.

Moreover, the physicians already face regulatory headwinds under current law and are very pessimistic about the future of medicine.

- Deloitte's 2013 survey of physicians found roughly *two-thirds of physicians* expected their colleagues will retire earlier than planned in the coming months, while *three in four* physicians believe the best and brightest students likely will not consider a career in medicine.[6]

- The Deloitte survey also found that *one in four physicians* said they planned to limit Medicare patients if there were payment changes.

Physicians are broadly opposed to the mandatory adoption of ICD-10.

The American Medical Association and other physicians' groups oppose requiring physicians to adopt these codes.

Adopting the Codes Will Not Directly Improve Patient Care or Outcomes

While public health entities supporting the adoption of ICD-10 understandably want more comprehensive data for conducting research and analysis, adopting these costly and burdensome codes will not directly improve patient care.

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[5] http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/' http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html?redirect=/erxincentive; http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/

[6] http://www.deloitte.com/view/en_US/us/Insights/centers/center-for-health-solutions/a5ee019120e6d310VgnVCM1000003256f70aRCRD.htm?id=us_furl_2013physciansurvey_031813

As an example of how outlandish and clinically irrelevant many of the codes are, let me give you a few examples.[7]

- The new codes account for injury sites, ranging from opera houses to chicken coops to squash courts.

- There are a total of nine codes strictly pertaining to injuries that occur in and around a mobile home.

- One code is for "burn due to water-skis on fire" and another for "walked into lamppost."

- According to George Alex of the Advisory Board Co., ICD-10 includes 72 codes pertaining to birds and 312 codes related to animals.

- The codes are so nuanced that "bitten by turtle" and "struck by turtle" are separate codes.

This is good late-night comedy material, but this is not good medicine.

Conclusion

In the summer of 2012, Dr. Coburn, along with co-author Dr. Jason Fodeman, penned a white paper on the problems with ICD-10 (enclosed).

They explained that "the costs of [the ICD-10 coding] changeover for hospitals already operating under narrow financial margins will be substantial," and "the adoption of the codes will, by default, force physicians to devote more time and energy toward coding, which may detract from patient care."

The paper also noted that while "the compliance costs of ICD-10 are tangible, the benefits are much more esoteric."

Those same concerns remain today. The problems with the ICD-10 coding system are real, and avoidable.

Adopting the codes would increase costs, burden providers, and not directly improve patient care. This amendment would prohibit that avoidable outcome.

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[7] Anna Wilde Mathews, "Walked Into a Lamppost? Hurt While Crocheting? Help Is on the Way," *Wall Street Journal,* September 13, 2011, at http://online.wsj.com/article/SB10001424053111904103404576560742746021106.html (April 13, 2012

Medicare Physician Incentives and Penalties

Year	Deficit Reduction Sequester*	E-Prescribing	Health Information Technology	Physician Quality Reporting System, including Maintenance of Certification (MOC) Program	ICD-10 Implementation	Value Based Modifier
2009		2%		2%		
2010		2%		2%		
2011		1%	$18K	1% if no MOC; 1.5% if MOC		
2012		1% (-1%)	$12-18K	0.5% if no MOC; 1.0% if MOC		
2013	(-2%)	0.5% (-1.5%)	$8-15K	0.5% if no MOC; 1.0% if MOC (performance year for 2015 penalty)		Performance year for 2015 penalty applied to groups of 100EPs or more
2014	(-2%)	(-2%)	$4-12K	0.5% if no MOC; 1.0% if MOC (performance year for 2016 penalty)	$100 to $50,000 penalty per HIPAA violation, depending on if it is knowing, willful & corrected	Performance year for 2016 penalty applied to groups of 100EPs or more
2015	(-2%)		$2-8K (-1%)	(-1.5%)		(-1%) for groups of 100 EPs or more
2016	(-2%)		$2-4K (-2%)	(-2%)		(-1%) for groups of 100 EPs or more
2017	(-2%)		(-3%)	(-2%)		VBM will apply to all physicians; policy TBD
2018	(-2%)		(-3%)	(-2%)		

Additional Penalties

*Deficit Reduction Sequester: The Budget Control Act of 2011 required automatic spending cuts of about $1.2 billion from 2013-2021 unless Congress enacted legislation reducing the federal deficit by that amount. Medicare cuts cannot exceed 2% of total program expenditures, not just claims for health care services. Thus actual cuts in payments to physicians and other providers could slightly exceed 2%. Note: the 2% would come on top of whatever cuts are scheduled for that year under the Medicare sustainable growth rate formula which is currently approaching 30 percent.

IPAB: The Independent Payment Advisory Board or IPAB is authorized to make reductions in payments starting in 2015 in order to meet statutory targets for Medicare spending growth as a percent of GDP. It is not known whether or how much physician payment rates will be affected.

ICD-10 Implementation Date: Better Never Than Later?

A White Paper on the Detrimental Effects of New ICD-10 Codes on Hospitals & Physicians

Summer 2012

By Senator Tom Coburn, M.D. and Jason Fodeman, M.D.

EXECUTIVE SUMMARY – *HHS recently announced hospitals and physicians have to adopt a new generation of diagnosis codes by October 1, 2014. Providers have to adopt what is effectively the tenth generation of the codes of International Classification of Diseases, known as "ICD-10." The main difference between the current ICD-9 codes and the new set, is there are many more codes, and they are filled with redundancies and unnecessary intricacies. The costs of this changeover for hospitals already operating under narrow financial margins will be substantial. The adoption of the codes will, by default, force physicians to devote more time and energy toward coding, which may detract from patient care. ICD-10 could indirectly accelerate the vertical integration of medicine and exacerbate the physician shortage. While the compliance costs of ICD-10 are tangible, the benefits are much more esoteric. As health care providers struggle to navigate the murky waters of health care reform, until more meaningful changes are made to lower costs and reduce administrative costs, HHS should halt ICD-10 implementation.*

INTRODUCTION

In a little less than two and a half years, hospitals, physicians, and providers will have to adopt a new coding system for services rendered. The International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) had been originally slated to replace the current ICD-9 coding system on October 1, 2013 until this past February when the Department of Health & Human Services (HHS) delayed ICD-10 implementation for an unspecified period of time. Recently, HHS announced the new ICD-10 implementation date would be October 1, 2014.[i] Advocates of this coding overhaul claim that it will foster better patient care, but in reality the mandate may do more harm than good.

ABOUT ICD-10

The main difference between the current ICD-9 and the new ICD-10 system is the sheer volume of codes. ICD-9 currently has approximately 18,000 codes while ICD-10 uses approximately 140,000 codes.[ii] Most of the increased number of codes is attributable to excessive details, not the unearthing of new diseases or medical pathology.

The new codes account for injury sites, ranging from opera houses to chicken coops to squash courts.[iii] There are a total of nine codes strictly pertaining to injuries that occur in and around a mobile home. One code is for "burn due to water-skis on fire" and another for "walked into lamppost." According to George Alex of the Advisory Board Co., ICD-10 includes 72 codes pertaining to birds and 312 codes related to animals. The codes are so nuanced that "bitten by turtle" and "struck by turtle" are separate codes[iv].

The ICD-10 system also incorporates anatomical location as well as surgical technique. ICD-10 transforms pressure ulcers –which under ICD-9 had nine codes pertaining to broad body locations and ignored wound depth– to 125 codes detailing much more precise anatomical coordinates and depth. Under ICD-10, angioplasty's one ICD-9 code will become 854 different codes highlighting body part, method, and instrumentation.[v]

THE DELAY

HHS made the correct decision in February to postpone ICD-10 implementation. A February 2012 survey by the Workgroup for Electronic Data Interchange (WEDI) of over 2,600 providers, health plans, and vendors indicated that the health care industry overall was not going to be ready for the originally scheduled adoption date. Approximately half of those providers surveyed stated they are unsure when they will finish their impact assessment. The survey also indicated that one quarter of health plans are only halfway through their assessments and that approximately half of vendors are not even halfway done with their product development.[vi]

A healthsystemCIO.com survey of its Chief Information Officer (CIO) Advisory Panel reiterated these sentiments. According to the survey, 72% of hospital CIOs believe the delay was in the best interest of their organization. The same survey found that 68% of CIOs believe the postponement will help the health care sector overall as well.[vii] While HHS' decision to delay the implementation of ICD-10 by one year may make the transition smoother for the health care industry, a better move would be to permanently delay ICD-10 as the costs and opportunity costs for hospitals and health care providers are certainly not worth the possible benefits.

COSTS FOR BUSINESSES AND CONSUMERS

The costs of the ICD-10 transition for hospitals and health care practices operating with narrow financial margins will be substantial. Health care providers will have to replace or modify existing IT software with expensive new IT systems that include the new codes. Practices will have to produce new superbills (physician billing forms) that incorporate the new ICD-10 codes as well. Hospitals will also have to train and educate various staff members in medical records, finance, and billing departments as well as doctors and clinicians who use these codes. During the transition period, hospitals will also have to hire tech support to troubleshoot and facilitate the ICD-10 changeover. Since provider contracts are based on ICD- 9, it is very likely that ICD-10 adoption will compel providers to renegotiate contracts with third party payers as well.

These expenses and others associated with ICD-10 adoption will carry a hefty price tag. Nachimson Advisors examined the financial burden that ICD-10 will impose on health care practices. They predicted that ICD-10 will cost a typical small practice of three physicians $83,290. They estimated that ICD-10 adoption for a medium practice of ten providers and for a large practice of 100 providers will cost $285,195 and $2.7 million; respectively.[viii] While James Swanson, director of client services at Virtusa, an IT services and consulting firm, believes ICD-10 conversion will cost big hospitals between two and five million dollars and that large health care networks could spend as much as twenty million dollars on the transition.[ix]

Not only will hospitals and health care providers have to purchase new technology to be ICD-10 compliant, but third party payers will as well. A survey from America's Health Insurance Plans (AHIP) of twenty health insurance plans concluded that ICD-10 will cost insurance plans on average twelve dollars per-member. For the twenty insurance plans, the survey found that ICD-10 implementation will cost $1.7 billion and AHIP predicts that it will cost two to three billion dollars across the entire health insurance industry.[x]

A 2004 RAND research paper estimated that the total cost of ICD-10 adoption will be $425 million to $1,150 million with annual productivity losses of five to forty million dollars.[xi] While the Hay Group in a 2006 white paper for AHIP predicted that the ICD-10 transition will cost the health care industry $3.2 to

$8.2 billion dollars.[xii] It is very likely that these costs will be passed along to patients in the form of higher prices or insurance premiums.

IMPACT ON PHYSICIANS AND PATIENTS

Since the implementation of Medicare in 1965, increasingly more and more already- scarce health care dollars have been devoted to nonclinical endeavors and more and more of a practicing physician's work day is directed toward ensuring compliance with an increasing number of regulatory requirements, instead of prioritizing care for their patients. ICD-10 implementation will exacerbate this counterintuitive trend.

Financially ICD-10 implementation will transfer limited health care money away from sick patients to administrators, businessmen, and IT consultants. In addition to carrying a hefty price tag, ICD-10 implementation will likely have a substantial opportunity cost on physicians trying to provide the best care for their patients as well. To satisfy this mandate, doctors will have to devote a significant amount of valuable time and energy to not only install ICD-10 into their practices, but to learn how to use it. This will take time away from patient care and serve as a major distraction to good medicine.

While keeping track of whether injuries occur on the "squash court" or at the "opera house" may be of interest to a narrow constituency it necessarily redirects time and money that could otherwise be directed toward improving quality of care or reducing consumer costs. Patients would be much better served having physicians perfecting their skills performing invasive techniques such as angioplasties, as opposed to learning hundreds of different ways to bill for it. The hours efforts doctors will have to spend to learn the nuances and complexities of ICD-10 would be best spent in the exam room actually treating patients.

Not to mention, physicians will only be able to bill for more detailed and intricate diseases if the documentation supports this level of specificity. As a result, this mandate will likely exacerbate the already stringent and exhaustive documentation burden on physicians, leaving them with even less time at the bedside. While compliance with ICD-10 will be frustrating for doctors, ultimately it will be the patients that suffer the most from less attention devoted to their care.

The time and hassle for private physicians to implement ICD-10 may also indirectly encourage the vertical integration of medicine. Doctors nearing retirement may find it easier just to leave medicine a few years early, rather than deal with learning the new coding system. If this happens, the adoption of ICD-10 could contribute to, and even encourage, the current physician shortage. Moreover, costs borne by physicians who are forced to adopt ICD-10 will further squeeze their operating margins. This could serve as a practical disincentive for physicians to accept more patients with Medicare or Medicaid coverage, since both programs already underpay physicians for their work compared to commercial insurance. Such a dynamics would further exacerbate the access problems that some patients on these government health plans already encounter when seeking care.

UNCLEAR BENEFITS

While the costs and clinical ramifications of ICD-10 are clear, the benefits are much more vague. ICD-10 advocates claim that it will facilitate smoother billing and limit the number of miscoded and rejected claims. However, it is hard to imagine that *increasing* the number of codes from 18,000 to 140,000 would simplify billing and reduce errors. To the contrary, it would seem very plausible that more coding options coupled with greater coding specificity would foster tremendous confusion amongst busy providers, which would likely increase – not decrease – the amount of miscoded and rejected claims.

ICD-10 proponents also claim that ICD-10 will make it easier for regulators and law enforcement officials to catch perpetrators of fraud. While that is perhaps possible, it seems more likely that implementation would produce new fraud charges against physicians and other providers who either did not understand or misunderstood one of the 140,000 new codes and subsequently improperly billed. While all appropriate efforts need to be made to reduce waste, fraud, and abuse in our health care system, mandatorily increasing the complexity of the system and then penalizing innocent errors seems wrong-headed, and it is avoidable.

The other cited benefits of ICD-10 adoption are more academic and epidemiological. Supporters contend that ICD-10 will foster better health care services research and public health surveillance. While there may be some marginal benefits, adoption clearly has real costs with regard to compliance and detracting attention from patient care. Unfortunately, with ICD-10 the associated costs in dollars and health care quality are simply too high to justify implementation.

POLICY RECOMMENDATIONS

As the costs of medical practice in this country continue to soar, practitioners need flexibility from regulators and legislators to deliver high quality care at an affordable price. This mandate does precisely the opposite. Its 140,000 codes replete with complexities, hilarities, and excesses are 140,000 steps in the wrong direction.

1. Congressional committees should hold hearings on ICD-10, evaluating the cost-benefit of this mandate from HHS. Highlighting the inevitable costs for both health care providers and patients will demonstrate the costs outweigh any marginal benefits.
2. HHS should take another look at ICD-10 and, until more meaningful and systemic steps are taken to reduce health care costs and the practice burdens on physicians and providers, HHS should halt implementation.
3. As physicians become inundated in more and more costly mandates, regulators at HHS and legislators in Congress should work with practitioners and hospital administrators to maximize scarce resources and ensure that they are devoted in the most effective way entirely towards patient care.

CONCLUSION

HHS made the right decision to delay ICD-10 by one year. However, the Department should not stop there. The adoption of 140,000 billing codes fraught with nuances, superfluous intricacies, absurdities, and redundancies could serve as a major distraction to physicians and other providers who are trying to provide the best care possible. Patients would be better served if doctors could devote less time and energy spent transitioning and learning ICD-10 codes, and devote more time to patient care. With a plethora of new mandates and regulations under the health care reform law, physicians and hospitals currently have a lot on their plate. With so many points of our health care system already being stressed, now is simply not the time for a revamping of the billing and coding system as well. We would do better to reduce the layers of unneeded regulations and complex codes that make it more challenging for physicians to put patients first. What is a better implementation date for ICD-10? Never – or at least not until other systemic steps are taken to reduce administrative burdens, lower costs, and improve quality. Until then, HHS should take another look at ICD-10 and halt its implementation to prevent this needless expenditure of consumers' and providers' time and money.

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ENDNOTES

[i] *HealthLeaders Media* Staff, "HHS Proposes One-Year ICD-10 Delay," *HealthLeaders Media*, April 9, 2012, at http://www.healthleadersmedia.com/content/HOM-278727/HHS-Proposes-OneYear-ICD10-Delay.html## (April 13, 2012).

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[iii] Anna Wilde Mathews, "Walked Into a Lamppost? Hurt While Crocheting? Help Is on the Way," *Wall Street Journal,* September 13, 2011, at http://online.wsj.com/article/SB10001424053111904103404576560742746021106.html (April 13, 2012).

[iv] Anna Wilde Mathews, "Walked Into a Lamppost? Hurt While Crocheting? Help Is on the Way," *Wall Street Journal,* September 13, 2011, at http://online.wsj.com/article/SB10001424053111904103404576560742746021106.html (April 13, 2012).

[v] Centers for Medicare & Medicaid Services, "ICD-10-CM/PCS An Introduction," at https://www.cms.gov/Medicare/Coding/ICD10/downloads//ICD-10Overview.pdf (April 13, 2012).

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[x] America's Health Insurance Plans, "Health Plans' Estimated Costs of Implementing ICD-10 Diagnosis Coding," September 2010, at www.ahip.org/SurveyICD-10CostsSept2010/ (April 13, 2012).

[xi] RAND, "The Costs and Benefits of Moving to the ICD-10 Code Sets," March 2004, at http://www.rand.org/pubs/technical_reports/2004/RAND_TR132.pdf (April 13, 2012).

[xii] Thomas F. Wildsmith, "Examining the Cost of Implementing ICD-10," *HayGroup*, October 12, 2006, at http://www.ehcca.com/presentations/hithipaa414/3_04_1.pdf (April 13, 2012).