



AMERICAN ACADEMY OF  
ORTHOPAEDIC SURGEONS

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## **“Examining ICD-10 Implementation”**

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House Committee on Energy and Commerce

Subcommittee on Health

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On behalf of the American Association of Orthopaedic Surgeons (AAOS), which represents over 18,000 board-certified orthopaedic surgeons, I would like to express our grave concern about the transition from the current International Classification of Diseases, version 9 (ICD-9) to ICD-10. This transition will be prohibitively costly to implement and will detract from patient care with very little benefit to the public health system.

The differences between ICD-9 and ICD-10 are substantial. The ICD-10 diagnosis set has 68,000 codes – a five-fold increase from the approximately 13,000 diagnosis codes currently in ICD-9 CM and the ICD-10 professional set, ICD-10 PCS, used for hospital procedure coding) has over 100,000 codes, a five-fold increase as well. This issue of expansion is particularly important to orthopaedics and musculoskeletal care whereas ICD-10 CM has more than 30,000 musculoskeletal codes and ICD-10 PCS has more than 45,000 orthopaedic and musculoskeletal codes. These numbers are too large for any sized practice to easily implement. Thus, the transition to ICD-10 will have a more negative impact on orthopaedics than any other physician specialty.

There are four main problems with implementing ICD-10 at this time:

- 1) ICD-10 is overly complex
- 2) It will be costly to implement
- 3) It will decrease physician productivity and patient access to care
- 4) It's poor timing – there are too many changes occurring at this time

### **Complexity of ICD-10**

There are thousands and thousands of codes – more than any other country in the world has in their version of ICD-10. Ours will be the only country which uses ICD-10 for billing purposes. The system will be onerous.

There are many rules and peculiarities which make it difficult to learn and use. For instance:

Sometimes a tendon rupture is a disease and sometimes it's an injury but it's not called a "rupture", it's a "strain".

An open fracture is the term used when the skin and soft tissues are damaged over a fracture and the bone is exposed. For many bones, there are specific codes for the open fracture – like open fracture of femur. For other bones, there is no open fracture code and

one must use two codes – one for the fracture and one for the associated open wound. One has to learn to master the inconsistencies.

Osteonecrosis is a term which describes localized bone death. It often affects the hip or knee. In ICD-10 there is no code for osteonecrosis of the hip or knee – there is only a code for the femur which really poorly localizes the problem.

ICD-10 incorporates a 7<sup>th</sup> character which more or less describes the status of treatment. In other words the ICD-10 code for a condition changes over time. This is a strange concept to current physicians and coders and must be learned. It is not clear how this is helpful to patients or professionals.

For the medical professional, it won't be possible to wake up on the morning of October 1<sup>st</sup> 2015 and practice business as usual. It will be necessary to spend hours of preparation putting the system of ICD-10 in place and learning how to use it.

### **Cost of Implementation**

The estimated implementation cost of ICD-10 is between \$83,000 and \$2.7 million, depending on the size of the practice (Nachimson Advisors).

Each physician and other professionals in the practice will need to take off work to attend ICD-10 training. This results in a cost for purchasing the training and the additional cost of lost productivity. These are all expenses which will not be reimbursed.

Each practice will need to purchase ICD-10 books, training manuals and software to use the system. There's too much to commit to memory – practices will need to have specific references.

Many physicians have a small enough scope of practice that each can currently bill for a patient encounter on a single sheet of paper called a "superbill". The physician simply checks off a diagnosis and a treatment and billing is complete. In ICD-10, there are too many codes for a single superbill. Each physician practice will likely need an electronic system of billing which means new hardware and billing software. These changes will require time and money.

Physicians who use third party billers or clearing houses will need to revamp their systems.

All of these changes will cost the physician time and money. This amounts to an unfunded mandate.

## **Decrease in Physician Productivity – Decrease in Patient Access**

Because of the increased granularity in ICD-10 it is going to take more time for the physician to document the specific detail required to arrive at the correct ICD-10 code and more time to choose the right code than it has in the past. More time per patient means, fewer patients per day, which means a decrease in productivity. Decrease in productivity results in decreased access to patient care.

Canada is our close friend and neighbor. When the Canadian healthcare system adopted ICD-10, there was an immediate drop in productivity of 30%. Productivity improved over time but never fully returned to pre-ICD-10 levels. It doesn't seem like our health care system can afford a hit like this.

In addition to decreased productivity is the added cost of denied claims. It is anticipated that early on in the transition to ICD-10, a significant percentage of claims will be denied or held back for payment. The AAOS has been advising orthopaedic practices to take out a line of credit equal to 6-months revenue at the beginning of the ICD-10 transition in anticipation that revenues will drop suddenly and precipitously as a result of the transition. This is a financial burden that many practices cannot sustain. In addition, orthopaedic practices will face tremendous burdens in verifying patient eligibility, obtaining pre-authorization for services, documentation of the patient's visit, research activities, public health reporting and quality reporting. Physicians who are unable to transition to ICD-10 by the implementation date simply will not get paid. All of these changes are made in order to transition to a code set that provides no patient care benefits nor physician reimbursement to offset these added costs.

## **Bad Timing**

Physicians in the USA are already reeling from several administrative changes affecting the practice of medicine. These include the many changes detailed in the Affordable Care Act, requirements for Meaningful Use of EMR, Value-Based reporting, unpredictability in the SGR, e-prescribing and the recent plans by CMS to eliminate 10 and 90 day global payments to physicians. The additional burden of converting to ICD-10 on 1 October 2015 is over the top.

Finally, despite the huge expansion in the number and specificity of ICD, the codes still need significant refinement. The AAOS has actively been working to update the ICD-10 CM and ICD-10 PCS systems but there are still significant gaps that need to be addressed before implementation.

## Summary

ICD 10 is a great system as it has been adopted by other first world nations. A great deal of work has gone into its development. Its use in studies of epidemiology may prove useful. In countries outside the United States where ICD 10 is used, the burden of implementation and documentation is borne by the government. The volume of codes is relatively small. The volume of codes in the system about to be adopted in the United States is greater than that in any other country in the world. The burden and expense of using the system is going to be born entirely by physicians, yet there is no clear benefit to physicians. There is no clear benefit to patient care, either. It is not clear that explosive and disruptive effects brought about by the implementation of ICD-10 on October 1<sup>st</sup> will be outweighed by an improvement in patient care

We are concerned that implementing ICD-10 will detract from patient care with very little benefit. According to the American Health Information Management Association and eHealth Initiative Survey, many respondents think coding, documenting patient encounters and adjudicating reimbursement claims will be harder under the new system. All of these issues inhibit the doctor-patient relationship, which is critical to quality care.

We believe that prohibiting the transition to ICD-10 will enable physicians and other stakeholders to assess an appropriate alternative to such a burdensome, regulatory requirement and help reduce costs weighing on physician practices, as well as help to keep new, more efficient models of health care delivery and payment on track. In the absence of prohibition of ICD-10, a two- year delay will enable physicians and other stakeholders an appropriate time frame to adjust to such a burdensome, regulatory requirement and help reduce costs weighing on physician practices. It will also help mitigate the disruption to physician practices when advancing to a new diagnostic code set.

Thank you for your attention to this important issue and we are happy to provide any follow up information that may be of assistance to the committee.

## Reference

The Impact of Implementing ICD-10, Nachimson Advisors, LLC October 8, 2008  
<http://www.nachimsonadvisors.com/documents/icd-10%20impacts%20on%20providers.pdf>