

Question from Rep. Pallone to Carmella Bocchino

Can you elaborate on how insurers are held back by ICD-9 codes currently in implementing delivery system reforms and how specifically the ICD-10 code data will help in those efforts.

Carmella Bocchino's Response

- The U.S. healthcare system is moving from fee-for-service, in which payment is based on the number of patients seen by a provider or the specific treatments provided, to models that base payment on outcomes and improvements in health quality. The goal of these payment reforms is to recognize and reward efforts to improve patient health and promote a healthier population. The transition from the current International Classification of Diseases, 9th Revision (ICD-9) to the 10th Revision (ICD-10) for diagnosis and procedure coding is essential to supporting these efforts.
- ICD-10 codes provide more specific and detailed information about a diagnosis or procedure allowing for better measurement of what was done, why the treatment was needed, and the outcome for the patient. For example, ICD-10 codes provide more detail on surgical procedures used to repair the heart and pericardium, leading to a better understanding of which procedures are most clinically effective depending on the underlying diagnosis.
- ICD-10 codes make it easier to obtain information without having to investigate the underlying medical record because the codes capture more detail. It is significantly easier to quantify the relationship between specific medical procedures (e.g., surgeries on the right or left side of the body) and outcomes (e.g., post-surgery infection sites) from a review of ICD-10 codes, than having to individually go through the unstructured surgeon's notes and medical records for each patient.
- A substantial number of ICD-10 codes combine diagnosis and symptoms (as opposed to the ICD-9 coding which may require several different codes to describe a patient's condition). This combination reduces the potential errors or confusion resulting from a provider having to use multiple codes to describe a single event. For example, a single ICD-10 code, E10331: type I diabetes mellitus with unspecified diabetic retinopathy and macular edema, requires three ICD-9 codes to convey the same diagnosis.
- ICD-10 codes provide additional sensitivity in describing diagnosis and procedures allowing providers to be better rewarded for more complicated and difficult interventions with positive outcomes. ICD-9 codes, which tend to treat all similar diagnosis and procedures the same, do not always recognize the different levels of care that may be required within the same treatment, based on the patient's condition.
- ICD-10 codes recognize new disease conditions, treatments, and medical devices. Medical knowledge and treatments are growing and the ICD-9 code set is extremely limited in its ability to adopt new codes. Additionally, ICD-10 codes can expand to

provide greater specificity as we learn more about an existing medical condition or diagnosis.

- ICD-10 codes enhance our ability to identify patients that would benefit from disease management and care coordination programs. Because of their greater specificity and flexibility, the new code system allows providers and payers to better monitor patients who need more intensive follow-up services and determine when disease management and care coordination programs have been effective.

Carmella Bocchino: Additional Discussion of Dual Tracking ICD-9 and ICD-10

In addition to my response to the question raised by Rep. Pallone, I wanted to provide additional information in response to questions from several members of the Subcommittee asking whether health plans might “dual-track” claims and other transactions for a period of time after the October 1, 2015 implementation date. In other words, could health insurers, self-funded employer plans, and government programs continue to accept transactions coded in either ICD-9 or ICD-10 for a period of time until all providers were willing to come into compliance with the new requirements? As discussed below, such dual-tracking would be extremely costly and difficult to implement, especially given the short time frame between now and October 1st.

To frame this discussion, it is important to note that health plans conduct millions of electronic health care transactions on a daily basis – and each health plan exchanges this data electronically with hundreds if not thousands of external trading partners (e.g., providers, vendors, clearinghouses) and internal end-users (e.g., claims processing, provider relations, customer services). Further, the codes impact almost every internal system that health plans use in their day-to-day business operations. As a result, requiring health plans to process one vs. two code sets for any period of time after October 1st will have a significant and very negative impact on health plan operations. We have included a chart with this letter demonstrating the complexity of utilizing two code systems and the impact on health plan administrative and operational systems.

Health plans will continue to accept and process claims and other transactions using ICD-9 codes for a period of time after October 1st but only for claims with a date of service prior to that date. This limited run-out of claims is not expected to last beyond a short period of time for a very small number of transactions. Continuing to pay claims using ICD-9 codes with dates of service before October 1st is very different from having to accept either ICD-9 or ICD-10 coded transactions for a period of time based on a provider’s decision of what codes to use.

Our members have identified specific concerns with any requirement to dual-track transactions:

- Complexity and administrative challenges from maintaining two systems to process claims and other transactions with different business rules depending on the codes used.
- Difficulty in reporting information (e.g., HEDIS), analyzing data, and tracking payments and patient outcomes given the differences between ICD-9 and ICD-10 coding systems.

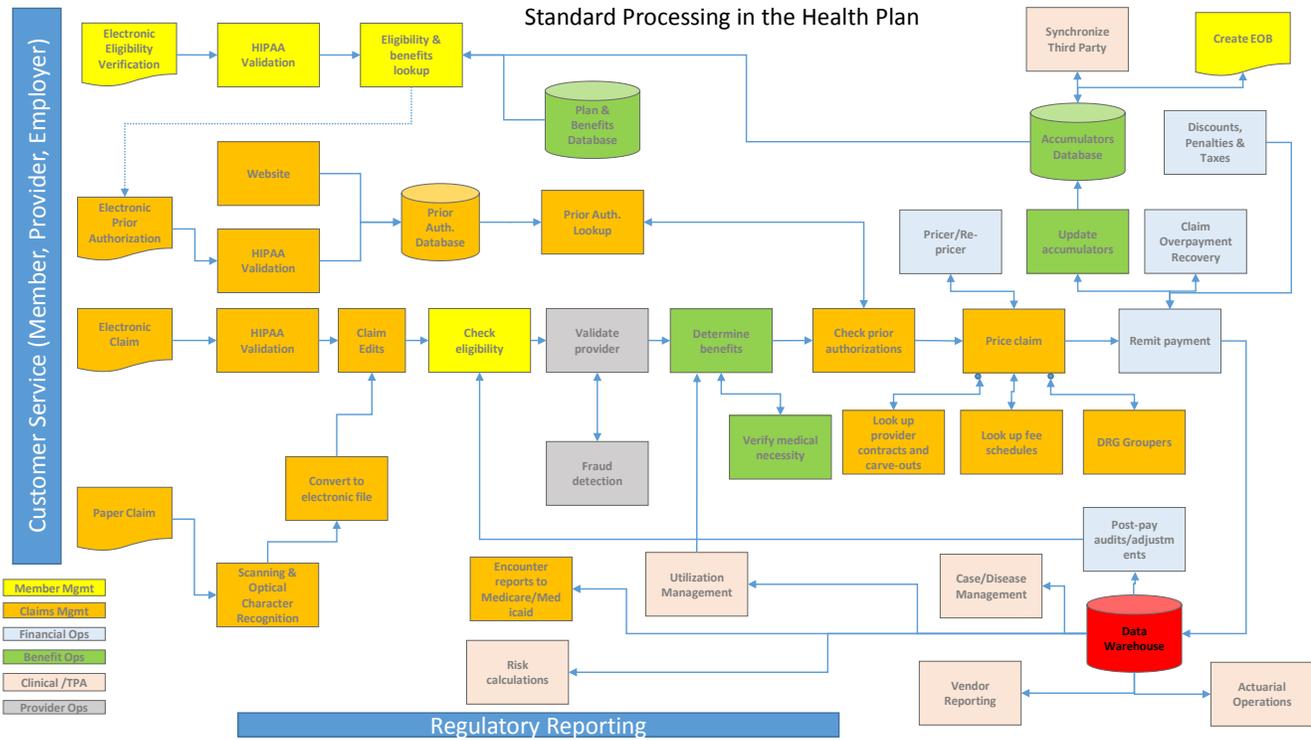
- Impact on fraud and abuse detection resulting from claims mixing the two code sets.
- Challenges to medical management, care coordination, and disease management programs due to a lack of uniform codes assigned to the diagnoses and procedures for an individual patient or group of patients.
- Increased potential for provider and payer confusion as well as processing and payment errors because providers, office management systems, coders, clearinghouses, and health plans will be switching between two different coding systems.
- Conflicts regarding the performance of health care activities such as quality assurance and disease management due to different providers submitting either ICD-9 or ICD-10 codes for the same diagnosis or treatment.
- Complications from mixed Diagnostic Related Group (DRG) using both code sets. DRGs combine medical “products” (e.g., an appendectomy) based on factors such as patient age and gender and the diagnosis/procedure code for payment purposes. Currently, DRGs are based on either the ICD-9 or ICD-10 assigned codes and it would be difficult to develop and test “mixed” code DRG logic.
- Having to continue provider outreach and training and other implementation activities beyond the October 1st implementation date leading to higher costs and resource demands.

In addition to these issues, our members relate two overall concerns with having to maintain two distinct coding systems over time. First, our members estimate the cost for maintaining two coding systems could be as high as \$10 million per health plan depending on the length of the delay in a full transition to ICD-10 and the number of providers that choose to continue use of ICD-9. This cost is on top of the hundreds of millions of dollars our industry has already expended to support ICD-10 implementation and the millions of additional dollars resulting from the multiple delays of the compliance date (several of our members who operate on a national basis estimate the delays have cost them upwards of \$100 million).

In addition, our members are concerned there will not be sufficient time prior to October 1st to establish and test dual processing systems. As noted, health plans support millions of daily transactions with a significant number of trading partners and internal end-users. Changing the current implementation plan which relies on a clean switch over to ICD-10 to a new, complex, untested, and administratively burdensome dual-track process cannot be done in a few months.

For these reasons, we believe the dual-tracking of transactions after October 1st would be significantly damaging to our health care system and should not be adopted.

Standard Processing in the Health Plan



Dual Processing Impacts in the Health Plan

