REVIEW

Ready or not! Here comes ICD-10

Laxmaiah Manchikanti,1 Frank J E Falco,2 Joshua A Hirsch3

ABSTRACT

The International Classification of Diseases-10 (ICD-10) is a new system that is a federally mandated change affecting all payers and providers, and is expected to exceed both the Health Insurance Portability and Accountability Act (HIPAA) and Y2K in terms of costs and risks. In 2003, HIPAA named ICD-9 as the code set for supporting diagnoses and procedures in electronic administrative transactions. However, on 16 January 2009, the Department of Health and Human Services published a regulation requiring the replacement of ICD-9 with ICD-10 as of 1 October 2013. While ICD-9 and ICD-10 have a similar type of hierarchy in their structures, ICD-10 is more complex and incorporates numerous changes. Overall, ICD-10 contains more than 141 000 codes, a whopping 71.2% increase over the <20 000 codes in ICD-9, creating enormous complexities, confusion and expense. Published statistics illustrate that there are instances where a single ICD-9 code can map to more than 50 distinct ICD-10 codes. Also, there are multiple instances where a single ICD-10 code can map to more than one ICD-9 code. Proponents of the new ICD-10 system argue that the granularity should lead to improvements in the quality of healthcare whereas detractors of the system see the same granularity as burdensome. The estimated cost per physician is projected to range from $25 000 to $50 000.

The US healthcare industry has been undergoing many changes and is poised to undergo many more radical changes in the coming years.1–6 The enormous pace of innovation in healthcare, increasing complexity of healthcare interventions and systems, pervasive and persistent unexplained variability in clinical practice and high rates of perceived inappropriate care combined with increased expenditures have helped fuel a steady increase in regulations and changes.7–10

The International Statistical Classification of Diseases and Related Health Problems, known as ICD, provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease.11 One significant policy change that we believe has been overshadowed by the current healthcare reform discussion is the ICD, 10th revision, or ICD-10.6 The rationale for transformation is that the greatly expanded ICD-10 coding system allows for more precision and specificity about both disease conditions and the healthcare interventions provided to patients; savings from elimination of inappropriate diagnoses and identification of fraud; and a suggestion that ICD-10 will allow the USA to report morbidity and mortality statistics to the WHO that are comparable with those of other countries.6 19 20

The costs for physician practices have been estimated to be steep, averaging over $83 000 for a three doctor practice, $285 000 for a 10 doctor practice and $2.7 million for a 100 doctor practice, based on a study conducted by the Medical Group Management Association.21 Furthermore, hospital expenses have been estimated to range from $15 million to $20 million per hospital. These are the best case scenario estimates, and some expect the cost to be considerably more.

BACKGROUND

The history of ICD dates back at least to 1763 when French physician Francois Bossier de Lacroix, seeking to aid his fellow physicians in making diagnoses, published a classification system listing 10 major classes of diseases and 2400 individual diseases.22

In 1855, the first International Statistical Congress appointed William Farr and Jacob Marc d’Espine to create an internationally acceptable classification of causes of mortality.23 Consequently, the general arrangement proposed by Farr was selected as the basis of the International List of Causes of Death (ILCD). The first ILCD was developed by a committee chaired by Jacques Bertillon (Chief Statistical Services of the City of Paris) in 1895, and was introduced at the International Statistical Institute in Chicago.24 In 1898 it was adopted by Canada, Mexico and the USA.25 Subsequently, ILCD classifications for mortality reporting were officially published in 1900, 1910, 1920, 1929 and 1938.25

The WHO became the custodian of ICD in 1948, and in 1949 adopted the ICD, which was expanded to include morbidity coding.26 As the WHO assumed responsibility for preparing and publishing the revisions in 1948, revisions have been performed every 10 years; thus WHO sponsored the seventh and eighth revisions in 1957 and 1968, respectively. The ICD-9 revision provided additional, detailed four digit level categories and some optional five digit subdivisions. ICD-9 was published in 1977 by the WHO Department of Knowledge Management and Sharing. However, the WHO no longer publishes or distributes the ICD-9 as it is now in the public domain.

Work on ICD-10 began in 1983 and was completed in 1992. The code set allows more than 155 000 different codes and permits tracking of many new diagnoses and procedures, a significant expansion on the 17 000 codes available in ICD-9.6 19 23 The unchanged international version of ICD-10 is used in about 110 countries for cause of death.
reporting and statistics. Nonetheless, many countries have not adopted it for mortality and morbidity coding. In 2003, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 named ICD-9 as the code set for reporting diagnoses and procedures in electronic administrative transactions. On 16 January 2009, the Department of Health and Human Services published a regulation requiring the replacement of ICD-9 with ICD-10 as of 1 October 2013. The ICD-10-CM will be used for diagnoses coding and the procedure coding system (ICD-10-PCS) for inpatient procedure coding.

All HIPAA-covered entities must make the change; a prerequisite to ICD-10 is the adoption of electronic billing (EDI) V5010 by 1 January 2012.

**EVOLUTION OF ICD-10**

The ICD-9-CM, the clinical modification of ICD-9, developed by the National Center for Health Statistics for reporting morbidities, was adopted for use in the US in 1979. In 1983, the Inpatient Prospective Payment System was adopted, and ICD-9-CM volumes 1, 2, and 3 were used for assigning cases to diagnoses related groups. As a result of the advances in medicine since ICD-9-CM was implemented, the system has been updated and revised periodically with the establishment of regular updates annually via a coordination and maintenance committee. Responsibility for maintenance of the ICD-9-CM lies with the National Center for Health Statistics and the Centers for Medicare and Medicaid Services (CMS).

HIPAA has identified 10 standard transactions for electronic data interchange for the transmission of healthcare data, claims and encounter information, payment and remittance advice, and claims status and inquiry. Code sets are the codes used to identify specific diagnoses and clinical procedures on claims and encounter forms. Such examples of code sets for procedures, diagnoses and drugs with which providers are familiar include Healthcare Common Procedures Coding System (HCPCS), Current Procedural Terminology (CPT), ICD-9 and National Drug Code (NDC).

**STRUCTURE OF ICD-10**

The ICD-10-CM has the same type of hierarchy in its structure as ICD-9-CM. All codes have the same first three digits describing common traits, with each character beyond the first three providing more specificity. However, ICD-10-CM is alphanumeric with up to seven digits of specificity. It also has the same organization and use of notes and instructions. When a note appears under a three character code, it applies to all codes within that category, and notes under a specific code apply to that single code.

However, there are substantial differences between ICD-9 and ICD-10. These are described as improvements in the content and format of the ICD-10-CM, which include:

1. The addition of information relevant to ambulatory and managed care encounters.
2. Expanded injury codes in which ICD-10-CM groups injuries by the site of the injury, as opposed to grouping in ICD-9-CM by type of injury or type of wound.
3. Creation of combination diagnoses and symptom codes, which reduces the number of codes needed to fully describe a condition.
5. V and E codes being incorporated into the main classification in ICD-10-CM.
6. ICD-10-CM codes being alphanumeric and including all letters except U.
7. The length of codes in ICD-10-CM being a maximum of seven characters, as opposed to five digits in ICD-9.
8. Some vacant, three character codes in ICD-10 to allow for revision and future expansion.

Overall, ICD-10-CM far exceeds its predecessors in the number of codes available. Table 1 illustrates the comparison of chapter numbers and titles in ICD-9-CM with those in ICD-10-CM. However, diseases of the eye and its adnexa and diseases of the ear and mastoid process will have their own chapters in ICD-10-CM.

ICD-10-CM characteristics are as follows:

- Tabular lists containing cause of death titles and codes (volume 1).
- Inclusion and exclusion terms for cause of death titles (volume 1).
- Alphabetic index to diseases and nature of injury.
- External causes of injury.
- Table of drugs and chemicals (volume 3).
- Description, guidelines and coding rules (volume 2).

Table 2 illustrates the differences between ICD-9 and ICD-10.

**LACK OF NEED FOR ICD-10 AND ITS COMPLEX MECHANISM**

ICD-10 proponents argue that in ICD-9 the number of diagnostic codes based on alphanumeric name badges the diagnoses carry for insurance billing and other purposes will increase from 14,000 to 69,000. In addition, the number of codes for procedures that can be performed on an inpatient basis in hospitals will jump from about 3,800 to 72,000. The shift will affect just about every aspect of clinical and business operations as the codes document what clinicians do with patients and are embedded in nearly all clinical information and billing operations nationwide. Proponents also agree that in effect, switching to ICD-10 means that every diagnosis and piece of claims activity will operate under a different language than it does now.

It has been argued that ICD-10 implementation requirements are much more extensive than any encountered with HIPAA to date, or even with Y2K. The most valuable lesson from both HIPAA and Y2K is that successful ICD-10 implementation will cost more than present estimations, potentially by a large amount. While it is guaranteed that the costs will be a part of ICD-10, the benefits are only potential. Understandably, physicians, hospitals, health plans, software vendors, government agencies and nearly all other healthcare entities bracing for the implementation of the inevitable ICD-10 coding system are anxious as ICD-10 introduces a monumental new set of diagnostic and procedural codes. The anxiety is most severe for small physician practices, hospitals and health plans which may not be ready for ICD-10 by the October 2013 deadline. An additional concern is that some organizations will not be ready for the transaction system conversion on 1 January 2012. In fact, ICD-10, similar to various healthcare regulations in the past, including implementation of HIPAA and the Occupational Safety and Health Administration (OSHA) compliance regulations, has created a cottage industry of consultants. While there is no proof of savings or improved efficiency, there are estimations of overriding costs and inconvenience for practitioners. These include overhauling computer software systems, training staff and making other needed changes. The Department of Health and Human Services projects a total cost to the US healthcare system to be in the range of $2.3 billion to $2.7 billion over a period of 15 years. Furthermore, other cost estimates are highly variable, with one consulting firm estimating $3.2 billion to as much as $8.3 billion and another consulting firm estimating $15.2 billion to...
The conversion of ICD-9-CM codes to ICD-10-CM codes will likely be very complicated. Supplementary table 1 (available online only) illustrates the select examples of codes utilized in neurointerventional practices, showing codes variable from 2 to 20 ICD-10 codes for each ICD-9 code. This example illustrates the complicated nature of conversion, creating further confusion. To understand the transition and mapping, one would need to expand multiple precious resources, including time and financial resources. Furthermore, as illustrated in table 3, one ICD-10 code represents multiple ICD-9 codes compounding the complexity and complications. The entire argument of granularity increasing and simplicity are lost with further restrictions than ICD-9.

### Practical Impact

To help facilitate care and commerce, the government has invested in providing mappings between ICD-9 and ICD-10 and vice versa. There are two such mappings endorsed by CMS: the general equivalence mappings (GEMs) (for both ICD-9 to ICD-10 and ICD-10 to ICD-9) and the reimbursement maps (for ICD-10 to ICD-9 only). The GEMs established links among codes that are generally equivalent in each code set. The reimbursement maps were created after the GEMs maps and are
more specific, identifying the top candidate mappings from within the GEMs.

Some published statistics\(^30\) may illuminate the challenges inherent in linking across the code sets. In the GEMs maps for procedures from ICD-9 to ICD-10, multiple examples are provided, although these are not specific to neurointerventional radiology or interventional pain management.\(^6\)

- There are 285 instances where a single ICD-9 code can map to more than 50 ICD-10 codes.
- There are 119 instances where a single ICD-9 code can map to more than 100 ICD-10 codes.
- Some GEMs maps of ICD-9 to ICD-10 are not specific:
  - There are 7239 instances in the mappings for diseases where a single ICD-9 code can map to more than one ICD-9 code.
  - There are 7241 instances in the mappings for procedures where a single ICD-9 code can map to more than one ICD-9 code.
  - In the reimbursement maps from ICD-10 to ICD-9:
    - There are 3684 instances in the mappings for diseases where a single ICD-10 code can map to more than one ICD-9 code.
    - There are 2135 instances in the mappings for procedures where a single ICD-10 code can map to more than one ICD-9 code.

Furthermore, different rules exist for different purposes. While CMS has tried to create clarity with GEMs and reimbursement mappings, the results are extremely disappointing. It has been shown that GEMs ICD-9 to ICD-9 mappings have a 5.1% exact match for diseases and only 0.1% exact match for procedures. In contrast, GEMs ICD-9 to ICD-10 mappings have an approximately 20.1% exact match for diseases and 1.2% exact match for procedures. With so few exact matches, it may be impossible for struggling practices to continue.

The troubles do not seem to stop with the different rules and different purposes and multitude of code changes. They are also related to adopting software with multiple crosswalk variations. Independent package software vendors will have different offerings and divergent approaches to cross walking. Some may support sophisticated rules and others will not.\(^30\)

- Either way, if medical systems, claims systems and financial systems have different tools, things will become extremely difficult, causing hardship. On some occasions, it appears the data may have to be entered into multiple programs. Wollman\(^30\) describes that any business rules for mappings would need to be entered and stored in at least five systems, plus any analytic systems that source data from the applications. Thus with cross walking systems the potential for errors and rework is astronomical, due to the over 250 GEMs mappings, approximately 150,000 reimbursement mappings and over 160,000 ICD-9/ICD-10 codes used to manage a total of approximately 600,000 records and potentially tens of thousands of overrides in addition to the GEMs and reimbursement maps. Most prudent practices and providers require at least 3 years of historical data for trending and analysis purposes.

  On September 30, 2013, all of this history will be encoded in ICD-10 nomenclature. On the following day and going forward, the ‘new history’ will start to be encoded in ICD-10. Consequently, any type of trending will either require a migration of all of the history to ICD-10 or some mechanism for stepping up ICD-9 codes to ICD-10 or stepping back ICD-10 codes to ICD-9 for analysis. However, it may be necessary to use both. Considering other major issues, this may be a minor problem.

**PREPARING FOR THE INEVITABLE**

Appropriate preparation about switching to ICD-10 is of paramount importance. Some of the most important concerns are as follows:

1. Whether organizations will be able to undertake the huge array of changes to make the conversion possible.
2. Whether organizations can do so on time to meet the government imposed deadline of 1 October 2013 for the transition.
3. Where does the money come from and is US healthcare ready for more expenses.

Timing is crucial to manage practices in the USA. Most provider systems, health plans and software vendors, despite reporting that they are on schedule in their conversions to ICD-10 and the new electronic transaction format, it is evident that some have not even started their preparations. As an example, the American Hospital Association survey in October 2010 found that only one-half to two-thirds of hospitals had taken the recommended planning and assessment steps.\(^19\) Not

---

**Table 2** Comparison between the WHO ICD-9 and ICD-10 classifications

<table>
<thead>
<tr>
<th>Name of classification</th>
<th>ICD-9 International Classification of Diseases</th>
<th>ICD-10 International Statistical Classification of Diseases and Related Health Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of volumes</td>
<td>(1) Volume 1—tabular list</td>
<td>(1) Volume 1—tabular index</td>
</tr>
<tr>
<td></td>
<td>(2) Volume 2—alphabetical index</td>
<td>(2) Volume 2—instruction manual</td>
</tr>
<tr>
<td>No of sections vs</td>
<td>17 sections (001—099)</td>
<td>21 chapters (A00-Z99)</td>
</tr>
<tr>
<td>chapters</td>
<td></td>
<td>Except for U codes</td>
</tr>
<tr>
<td>Supplementary</td>
<td>Two supplementary classifications</td>
<td>U00—U49: reserved for the provisional assignment of new diseases of unknown causes</td>
</tr>
<tr>
<td>classifications</td>
<td>(1) External causes of injury and poisoning (E800—E899)</td>
<td>U50—U99: for research purposes</td>
</tr>
<tr>
<td></td>
<td>(2) Factors influencing health status and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>contact with health services (V01—V82)</td>
<td></td>
</tr>
<tr>
<td>Categories</td>
<td>909</td>
<td>2036</td>
</tr>
<tr>
<td>Subcategories</td>
<td>5181</td>
<td>12 158</td>
</tr>
<tr>
<td>Total codes</td>
<td>6882</td>
<td>12 420</td>
</tr>
</tbody>
</table>

\(^3\)Source: Jette N, et al.\(^22\)
surprisingly, many providers are not even aware of ICD-10 changes, let alone the implementation date. Very few physicians have completed the impact survey. This is a major issue for smaller practices.

**CONCLUSION**

There are numerous issues related to ICD-10. None of the issues has been addressed appropriately as part of healthcare reform. Thus far, there is no scientific evidence for ICD-10

### Table 3

<table>
<thead>
<tr>
<th>ICD-10</th>
<th>ICD-9</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I6359</td>
<td>433.31</td>
<td>Multiple and bilateral pre-cerebral artery occlusion/stenosis with cerebral infarct</td>
</tr>
<tr>
<td></td>
<td>433.81</td>
<td>Other specified pre-cerebral artery occlusion/stenosis with cerebral infarct</td>
</tr>
<tr>
<td></td>
<td>434.91</td>
<td>Cerebral artery occlusion, unspecified with cerebral infarction</td>
</tr>
<tr>
<td>I6601</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I6602</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I6603</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I6609</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I6611</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I6612</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I6613</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I6619</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I6621</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I6622</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I6623</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I6629</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I663</td>
<td>434.00</td>
<td>Cerebral thrombosis w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
<tr>
<td>I669</td>
<td>434.10</td>
<td>Cerebral embolism w/o cerebral infarction</td>
</tr>
<tr>
<td></td>
<td>434.90</td>
<td>Cerebral artery occlusion, unspecified w/o cerebral infarction</td>
</tr>
</tbody>
</table>
implementation based on the principles of evidence based medicine, as dictated by US authorities and world authorities. The US healthcare system has been overwhelmed with numerous regulations, many of which are not particularly well understood. ICD-10 will be a new blow to the healthcare system at a time when the Independent Payment Advisory Board (IPAB), Patient-Centered Outcomes Research Institute (PCORI) and other initiatives related to evidence based medicine, quality and access are struggling to come out.

The authors favor postponing implementation of ICD-10 and prefer a focus on core issues of improving care and access.

Acknowledgments

We would like to thank Pain Physician for providing permission to publish in an abbreviated form.

Competing interests

None.

Contributors

LM wrote the rough draft and completed the initial research. FJEF and JAH proofread the draft and provided information to add to the manuscript. JH supplied information for the tables.

Provenance and peer review

Not commissioned; externally peer reviewed.

REFERENCES

Ready or not! Here comes ICD-10

Laxmaiah Manchikanti, Frank J E Falco and Joshua A Hirsch

*J NeuroIntervent Surg* 2013 5: 86-91 originally published online October 24, 2011
doi: 10.1136/neurintsurg-2011-010155

Updated information and services can be found at:
http://jnis.bmj.com/content/5/1/86

These include:

**Supplementary Material**
Supplementary material can be found at:
http://jnis.bmj.com/content/suppl/2011/10/24/neurintsurg-2011-010155.5.DC1

**References**
This article cites 16 articles, 1 of which you can access for free at:
http://jnis.bmj.com/content/5/1/86#BIBL

**Email alerting service**
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

**Errata**
An erratum has been published regarding this article. Please see next page or:
/content/5/6/621.1.full.pdf

**Topic Collections**
Articles on similar topics can be found in the following collections

- Socioeconomics (63)

**Notes**

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/
LETTERS TO THE EDITOR

Response to ready or not! Here comes ICD-10

In October 2011 JNIS published our article on the implementation of the ICD-10 codes.1 The final line of the paper was “The authors favor postponing implementation of ICD-10 and prefer a focus on core issues of improving care and access.”

The Centers for Medicare and Medicaid Services will require all health professionals and facilities to transition to ICD-10 by October 2013. ICD-10 is viewed as being more nuanced and providing a greater level of detail for what had led to an injury or illness. ICD-9 has 14 000 codes. As outlined in the article, implementing ICD-10 nationally will require tremendous allocation of resources. The upcoming change would require practices to learn 69 000 new codes for billing purposes. The American Medical Association (AMA) apparently agrees. During the 65th House of Delegates Interim Meeting of the AMA on 15 November 2011,2 delegates adopted a policy to work to stop implementation of the new diagnosis coding set ICD-10. Alabama and Mississippi delegations, the American Association of Clinical Urologists and the American Urological Association introduced the resolution to stop ICD-10 implementation.

“The implementation of ICD-10 will create significant burdens on the practice of medicine with no direct benefit to individual patients’ care,” said AMA President Peter W Carmel. “At a time when we are working to get the best value possible for our healthcare dollar, this massive and expensive undertaking will add administrative expense and create unnecessary workflow disruptions. The timing could not be worse, as many physicians are working to implement electronic health records into their practices. We will continue working to help physicians keep their focus where it should be—on their patients.” We are penning this brief letter to the editor because we see this AMA position as a relevant postscript to the paper.

Joshua A Hirsch,1 Laxmaiah Manchikanti2
1Department of NeuroInterventional Radiology, Massachusetts General Hospital, Boston, Massachusetts, USA
2Pain Management Center of Paducah, Paducah, Kentucky, USA

Correspondence to Dr Joshua A Hirsch, Department of NeuroInterventional Radiology, Massachusetts General Hospital, 55 Fruit Street, Gray 241B, Boston, MA 02114, USA; hirsch@snnonline.org

Competing interests None.

Provenance and peer review Not commissioned; internally peer reviewed.


Accepted 29 February 2012
Published Online First 22 March 2012

REFERENCES

PostScript