Who Cares about ICD-10?  
(Or, Why ICD-10 is Important to EMS as Part of the Broader Healthcare System)

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EMS has been fighting for years to be considered part of the healthcare continuum of care, and the imposition of ICD-10 onto prehospital care is a sign that the message is getting through. That’s a good thing, but it also means change. At a time when deadlines for everything from NEMSIS v3 to quality reporting metrics can seem more flexible than they should, the definitive adoption of the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) means reengineering processes that will take time to get used to. But in the end, they will facilitate Medicare payments and reduce fraud, especially in light of Accountable Care, Shared Savings, and readmission prevention under the Affordable Care Act.

Before digging into the technical implications of switching from ICD-9 to ICD-10, it would help to understand the “why” of this process.

First: Realize that the transition from ICD-9 to ICD-10 is a common pain across all U.S. healthcare institutions that engage in medical billing. The rest of the world cringed just as we are when it came time to switch over their systems…twenty five years ago. We will recover, too, but we need to catch up: according to Health Affairs, the World Health Organization adopted ICD-10 back in 1990, and the “United States is the only G7 nation (the other G7 nations are Canada, France, Germany, Great Britain, Italy, and Japan) continuing to use ICD-9.” ICD-10 has been controversial, but for business reasons—questions of cost. With respect to gaining clinical, statistical, and operational insights, there seems to be little dispute about the value of the new system, which “has the potential of improving the health care system, but its costs and complications have caused some to question whether the costs outweigh the benefits.” As Maggie Adams, president of EMS Financial Services, wrote in July 2015:

We graduate in October [2015] to ICD-10 going from the 13,000 codes available now under ICD-9 to over 68,000 codes under ICD-10. The change allows more in-depth description of the type of healthcare service we provide. The goals of gathering better information about emergencies via the use of ICD-10 is to help us prevent injuries and deaths. For EMS, this means that there will be a better way to track the external cause of injuries…

Second: While ICD-10 coding will be a burden at first (like learning any new software or skill), it will ultimately prove its worth. ICD-10 provides a common, code-delineated language to describe, on a far more granular level than ICD-9, the reason behind the patient’s contact outreach to EMS, and the
medic’s view of the patient’s condition. Practically speaking, this means that from Wichita to Washington and Louisiana to Las Vegas, every EMS agency, billing company—and yes, even every hospital-side electronic health record system—will be able to place the codes in context and get a very detailed understanding of what EMS did for the patient and why. This is a vital step toward establishing a common base of understanding and underscoring EMS’s place in the continuum. Indeed, perhaps ironically, given the range of clinical situations that EMS encounter, ICD-10 may be more relevant to us than to other members of the healthcare community. For example, EMS are likely to arrive on-scene before any other healthcare provider in response to a report about an animal bite or vehicular accident. ICD-10 allows for materially more nuanced documentation of the bite or collision. Here is another example from Ms. Adams:

Take the patient who nearly drowned. Under ICD-9, the emphasis was on the activity that occurred at the time of the event, for example, swimming or diving...Under ICD-10 coding, details will be needed about the type of water involved (for example, swimming pool, natural water or bathtub). Having statistics on where near-drowning events transpire may lead to better safety measures and education that prevent drowning accidents. In this case, emergency providers’ documentation about the mechanism of injury can make a difference to public health and safety....as well as enabling the claim for emergency service to be properly designated and filed for reimbursement.

Under ICD-9, accidents involving transportation were grouped by the type of vehicle involved in the accident. For ICD-10, we need to understand not only the mechanism of injury (motor vehicle accident involving an SUV engaged with a school bus on a highway overpass) but also the characteristics of the person who was injured (passenger in an auto, pedestrian or a two-wheeled or three-wheeled cyclist)...The beauty of ICD-10 is that there will be greater emphasis on documentation about the patient, the history of the present incident and the impact the event had on the patient’s body – in essence, the “where, what and how” of the mechanism of injury.3

Technology’s role thus becomes getting those clinical details to the receiving facility as quickly as possible—ideally, before the patient reaches his or her care destination. ePCR and billing software processes that used ICD-9 can build upon ICD-10 to go deeper and process more nuanced analytics. Your ePCR vendor can implement design-level changes to help ease the pain of the transition by helping you navigate the many new options in dropdowns and other lists. At the same time, trainers would do well to explain that, like moving to NEMSIS v3, the pain of expanded documentation is one that everyone is going through, and that everyone will come through on the other side more insightful and more engaged with the rest of the healthcare system.

EMS agencies will mostly rely on their patient care record providers to comply with ICD-10 coding and ensure sufficient granularity is available in the records being submitted to Medicare for reimbursement. Keep in mind that the deadline for ICD-10 has already passed. Ms. Adams notes that “denials are expected” and that “billing staff will know if documentation they see has information they need to properly select ICD-10 codes. Are the billers saying the usual, ‘we don’t have enough signatures,’ or are they saying, ‘we can’t figure out how to prepare this claim based on what’s is in the trip report.’”4 The trip report—or patient care record—is the basis for reimbursement, yet it is still viewed by many EMS professionals as a “necessary evil,” or in extreme cases, a burden best avoided altogether. Like NEMSIS v3, however, the nuance associated with coding for ICD-10 is too much to do on paper. Therefore, your first step (if you have not already made the switch) should be to ask your ePCR vendor to demonstrate its ability to output ICD-10 by running a test with your billing agency. Once you know that the system is capable of outputting ICD-10, the next step is to work with your vendor on usability design, offering insights from the field as to what would make it easier to sift through far more options.

Here’s the bottom line: unless the statistical orientation of NEMSIS v3, ICD-10 is by contrast fundamental to billing—and therefore, to continued business operations. Some ePCR vendors have been cited for exaggerating their NEMSIS v3 compliance. If the same thing happens with ICD-10, EMS agencies are likely to see their finances negatively impacted. Remember that no matter what a company has written on its website or claimed in a sales meeting, “marketing truth” won’t pay the bills.
3 Ibid.