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The Tragedy of the Implementation of ICD-10-CM as ICD-10: Is the Cart Before the Horse or Is There a Tragic Paradox of Misinformation and Ignorance?

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The forced implementation of ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) codes that are specific to the United States, scheduled for implementation October 1, 2015, which is vastly different from ICD-10 (International Classification of Diseases, Tenth Revision), implemented worldwide, which has 14,400 codes, compared to ICD-10-CM with 144,000 codes to be implemented in the United States is a major concern to practicing U.S. physicians and a bonanza for health IT and hospital industry. This implementation is based on a liberal interpretation of the Health Insurance Portability and Accountability Act (HIPAA), which requires an update to ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) and says nothing about ICD-10 or beyond. On June 29, 2015, the Supreme Court ruled that the Environmental Protection Agency unreasonably interpreted the Clean Air Act when it decided to set limits on the emissions of toxic pollutants from power plants, without first considering the costs on the industry. Thus, to do so is applicable to the medical industry with the Centers for Medicare and Medicaid Services (CMS) unreasonably interpreting HIPAA and imposing existent extensive regulations without considering the cost.

In the United States, ICD-10-CM with a 10-fold increase in the number of codes has resulted in a system which has become so complicated that it no longer compares with any other country. Moreover, most WHO members use the ICD-10 system (not ICD-10-CM) only to record mortality in 138 countries or morbidity in 99 countries. Currently, only 10 countries employ ICD-10 (not ICD-10-CM) in the reimbursement process, 6 of which have a single payer health care system.

Development of ICD-10-CM is managed by 4 non-physician groups, known as cooperating parties. They include the Centers for Disease Control and Prevention (CDC), CMS, the American Hospital Association (AHA), and the American Health Information Management Association (AHIMA). The AHIMA has taken the lead with the AHA just behind, both with escalating profits and influence, essentially creating a statutory monopoly for their own benefit. Further, the ICD-10-CM coalition includes 3M which will boost its revenues and profits substantially with its implementation and Blue Cross Blue Shield which has its own agenda. Physician groups are not a party to these cooperating parties or coalitions, having only a peripheral involvement.

ICD-10-CM creates numerous deficiencies with 500 codes that are more specific in ICD-9-CM than ICD-10-CM. The costs of an implementation are enormous, along with maintenance costs, productivity, and cash disruptions.

Key words: ICD-10-CM, ICD-10, ICD-9-CM (International Classification of Diseases, 10th Revision, Ninth revision, Clinical Modification), Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology (HIT), costs of implementation

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Implementation of ICD-10-CM codes (International Classification of Diseases, Tenth Revision, Clinical Modification) in the United States, which is scheduled for October 2015, has caused angst as much as any other forced implementation of regulations on medical practices (1). The so-called transition from ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) to ICD-10-CM is not a simple task as has been described, but is a near Herculean effort, transitioning an increase in codes from about 14,400 to 144,000 (2-4). The atmosphere in the United States is being described as a regulatory tsunami with regard to the Health Insurance Portability and Accountability Act (HIPAA) (5); numerous components of the Affordable Care Act (ACA), including electronic health records (EHRs) with almost 2,200 quality metrics; the Physician Quality Reporting System (PQRS); value-based payment system; costing as much as \$700 million for implementation at a single facility (Duke University) and \$1.4 Billion for Partners Health Care of Boston, as much as to construct a new 500-bed hospital (6-12); the statutory monopoly of the American Medical Association (AMA) with Current Procedural Terminology (CPT); and the Relative Value Update Committee (RUC) with numerous codes (13).

ICD-10-CM is neither a simple regulation nor a simple administrative burden, as other regulations are (14-16). Contrary to adopting ICD-10 with 14,400 different codes used worldwide, the United States, with its clinical modifications, ICD-10-CM has expanded the codes to 144,000 (2-4,17-24). The complicated and elaborate multi-axial system adopted in the United States does not correlate with codes utilized in any other country. The proponents of ICD-10-CM claim that: 1) the United States lags behind other countries related to outdated clinical data, 2) the costs of implementation are only modest, and 3) many have spent significant amounts with the expectation of a return on investment (Health Information Technology [HIT]) and show many of the hypothetical advantages (25). Any attempts to provide appropriate information is portrayed as disturbing trends, branded as weird politics, and ridiculed (26-29). An Alabama resolution (27,28), which urged Congress to consider appropriating funds to cover the significant cost and administrative burden of this unfunded mandate and became the subject of deridement for benefitting parties (25,26).

However, what is not being clearly communicated is that proponents are benefitting from the implementation of ICD-10-CM, such as the American Health Infor-

mation Management Association (AHIMA), the American Hospital Association (AHA), 3M Company, and many others. Skyrocketing profits, consultants making 2 to 3 times the income of an average physician, and programmers with the same income as a physician are creating another statutory monopoly for HIT in general, and for the AHIMA and the AHA in particular. The major issue is related to the misinformation provided by the HIT industry and the 4 non-physician cooperating parties preparing ICD-10-CM. They describe ICD-10 and ICD-10-CM as the same and ignorance of the facts by authorities make them unable to reconcile the truth and appropriate information (2-4,17-24).

DEVELOPMENT OF ICD-10-CM

Health Insurance Portability and Accountability Act (HIPAA), regulating health care transactions, national identifiers, and health care fraud and abuse (5,30), has provided the Centers for Medicare and Medicaid Services (CMS) with a vague basis to update ICD-9 which has been interpreted by CMS as ICD-10 implementation (21). Subsequent to HIPAA, numerous changes took place in the health care industry with continued escalating costs, despite numerous measures to curb the costs and to increase access with the passage of the ACA (6-8). In 2009, the Department of Health and Human Services (HHS) in their final rule decided that classification of diseases, ICD-9 diagnosis, and procedure codes must convert from using ICD-9 to ICD-10 on October 1, 2013 (30). Since then there have been 2 extensions through October 1, 2014, and subsequently October 1, 2015 (31,32). Unfortunately, the United States has linked ICD-10-CM to reimbursement for health care services unlike any other country.

The development of ICD-10-CM is managed by 4 non-physician groups known as cooperating parties, which include the Centers for Disease Control and Prevention (CDC), CMS, AHA, and AHIMA. Of the 4, AHIMA seems to be the pivotal and dominant organization, followed by AHA. Further, the ICD-10-CM coalition includes 3M, which makes significant profits from implementation of ICD-10 with consulting and software, as well as selling rather poorly designed Ambulatory Payment Classification (APC) software to Medicaid programs and others, and Blue Cross Blue Shield which has its own agenda. The decision by the Energy and Commerce Committee to not consider further postponement of ICD-10 was based on the testimony of 3M to avoid any postponement of ICD-10 (33). However, physician groups are not members of the cooperating

parties. Physicians are only involved peripherally. Consequently, the lack of physician input and domination by the HIT and hospital industries, with their social media and financial might, provides no basis for survival of opponents to ICD-10-CM.

The development of CPT codes and their evaluation through the CPT and Relative Value Scale Update Committee (RUC) process of the AMA is governed by a few major organizations without transparency, evidence basis, or even logic (13,34-39). The AMA also follows a similar philosophy and these codes and values are utilized by CMS the majority of the time with no alteration with CMS's lack of ability to control the process except to reduce payments for some providers. The same philosophy is being applied with the creation of a monopoly for AHIMA and AHA.

In fact, open records analysis of tax returns of these organizations show that the AMA has collected almost \$190 million from publishing activities, which contributed approximately \$100 million to their profit margin in 2013. AHIMA, ever since the passage of ICD-10-CM regulation in 2009, has increased its total revenue from \$25 million to \$46 million in 2013, a 65% increase. Above all, AHIMA has increased its net income from a loss of \$2.9 million to a profit of \$8.8 million in 2013. While all these organizations are listed as "not-for-profit", the executives of these organizations, specifically the AHA, have resulted in many of them ranging in salaries per year from \$1 million to over \$3 million with the AMA topping \$1.4 million, whereas the AHIMA salaries range from \$200,000 to \$450,000. Consequently, we believe that Congress has created 2 statutory monopolies with the AMA monopolizing the CPT and RUC process and the AHIMA monopolizing ICD-10. The AHA is a major beneficiary in this process, along with the health IT industry, represented by AHIMA.

MULTIAXIAL ASPECTS OF ICD-10-CM

ICD-10 has been described as one of the most onerous regulations thus far and as a major weapon for the extinction of the independent medical profession.

The advantages described are granularity and specificity, increasing from 14,400 to 144,000 codes for ICD-10-CM, policy makers obtain needless specificity, absurd adherence taxonomy, unnecessary detail about injuries, and insufficient additional information about chronic illnesses to justify its use (40-42). Singer (8), in a commentary, wrote that medicine has slowly evolved into the domain of technicians, bookkeepers, and clerks. He also emphasized that government inventions over

the past 4 decades have yielded a cascade of perverse incentives in a regulatory atmosphere with economic pressures that have forced practitioners to sacrifice independent medical judgment and, in essence, their integrity (8). Many physicians are joining hospitals, giving up their autonomy for life as a shift-working hospital employee, and others are threatened with bankruptcy. ICD-10-CM may be the final straw of increasing pressure on physicians, leading to the destruction of independent practices.

The coding revolution is not new. It started in the 1980s with price controls and the mandatory requirement to use ICD and CPT codes for reimbursement purposes (13,38,39). Subsequently, the Resource Based Relative Value Scale (RBRVS) was introduced, with each procedure being assigned a specific value by a panel of so-called experts, is based supposedly upon the amount of time and labor which is required. In contrast to physician payments, hospital payments were based on Diagnosis Related Groups (DRG), and outpatient services were based on the prices determined by CMS. With CPT and RUC, physician payments have been thrown into disarray, whereas DRG and Hospital Outpatient Department (HOPD) payments remained stable with increases over a period of time. Physician organizations, specifically the AMA, cooperated and traded the independence of all physicians (even though they represented only one-fifth of physicians), and their professional latitude for the ability to maintain a statutory monopoly, and their income levels by maintaining CPT codes (13,34-39,43-45). Thus, the goal of physicians setting their own prices has proven to be elusive and faced substantial criticism (13). With the rapid evolution of EHRs, Accountable Care Organizations (ACOs), a value-based payment system, which often has meaningful use requirements, sequester payment cuts, and more recently their merit-based payment systems, physicians have been drowning (9,10,46). Now ICD-10 just may push them into hospitals.

Numerous manuscripts in peer-reviewed journals and other publications have highlighted the bizarre aspects of these codes (17-21,40-42,47-50). ICD-10-CM creates numerous deficiencies. There are over 500 codes that are more specific in ICD-9-CM than in ICD-10-CM. There are over 3,600 instances in ICD-10-CM coding which can map to more than one ICD-9-CM code.

Post surgery syndrome in the spine has been represented in ICD-9 with 4 separate codes describing the regions; however, ICD-10-CM describes this with only one code, which may lead to significant confusion and numerous denials.

Congenital malformation of the spine not associated with scoliosis is described with one ICD-10-CM code; whereas in the ICD-9 there were 5 codes. There are numerous other codes where a diagnosis can't be properly communicated utilizing ICD-10-CM.

There are 119 instances where a single ICD-9 code can map to more than 100 distinct ICD-10 codes. There are over 255 instances where a single ICD-9 code can map to more than 50 ICD-10 codes. Not surprisingly, the bizarre coding also includes the following codes:

- Subluxation stenosis of neural canal of head region
- Osseous stenosis of neural canal of head region
- Connective tissue stenosis of neural canal of head region
- Osseous and subluxation stenosis of intervertebral foramina of head region
- Connective tissues and disc stenosis of intervertebral foramina of head region
- Subluxation stenosis of neural canal of lower extremity
- Subluxation stenosis of neural canal of upper extremity
- Osseous stenosis of neural canal of pelvic origin
- Osseous stenosis of neural canal of lower extremity
- Intervertebral disc stenosis of neural canal of upper extremity
- Intervertebral disc stenosis of neural canal of lower extremity
- Intervertebral disc stenosis of neural canal of rib cage

The spinal canal does not present in any of these regions.

There are multiple other codes just in the spinal stenosis category. Many of the codes describe extremity disorders, such as reflex sympathetic dystrophy and causalgia. They describe right upper and lower extremity, left upper and lower extremity, and also unspecified upper limb and lower limb.

Finally, we will learn how many Americans have 6 extremities instead of 4.

David Pittman (47) writing about the ICD-10 in "Follies: Bug bites", described the codes for injuries sustained in a collision with a bicycle, while knitting and crocheting, or gardening and landscaping, or in a collision with a balloon. There are also codes assigned to cases where a patient has been injured in a spacecraft collision, sucked into a jet engine, or even bitten by a parrot (41). Steven Syre (49) criticized that it is not good enough that documentation shows an incident happened at a cultural event, but it requires separate codes for injury at museums, art galleries, music halls/theaters, and opera houses. Tables 1 and 2 show some of the unusual codes arriving in ICD-10-CM implementation.

OUTDATED CLINICAL DATA

Proponents claim that ICD-9 is more than 35 years old and with its limited ability to store clinical data, it is inconsistent with current medical practices (42,51). However, they do not mention ICD-9-CM which went into effect in 1996 and has been modified ever since on a yearly basis.

ICD-10-CA implemented in Canada from 2001 through 2005 has shown plummeting productivity,

Table 1. *Some funny codes for ICD-10-CM.*

Codes for injuries in opera houses, art galleries, squash courts, and 9 locations in and around a mobile home, from the bathroom to the bedroom.
Medical problems related to a duck, macaw, parrot, goose, turkey, or chicken are associated with 9 codes for each animal.
Codes for injuries received while sewing, ironing, playing a brass instrument, crocheting, doing handcrafts, or knitting (but not shopping)
Other interesting codes:
- R46.1 is "bizarre personal appearance"
- R46.0 is "very low level of personal hygiene"
- W22.02XA, "walked into lamppost, initial encounter"
- W22.02XD, "walked into lamppost, subsequent encounter"
- V91.07XA, "burn due to water-skis on fire"
Sibling rivalry
Acquired absence of unspecified great toe
Prolonged stay in weightless environment

Are There Any Difference Between ICD-10 and ICD-10-CM?

Table 2. *Irrelevant descriptions of ICD-10-CM codes.*

W55.21	Bitten by a cow
W61.33	Pecked by a chicken
V00.01	Pedestrian on foot injured in collision with roller-skater
Y92.146	Swimming pool of prison as the place of occurrence of the external cause
Z63.1	Problems in relationship with in-laws
Y92.241	Hurt at the library
Y92.253	Hurt at the opera
Y93.D1	Accident while knitting or crocheting
W56.22	Struck by Orca, initial encounter
W56.32	Struck by marine mammals
W56.11	Bitten by sea lion
V91.07	Burn due to water-skis on fire
V91.35	Hit or struck by falling object due to accident by canoe or kayak
V94.810	Civilian watercraft involved in water transport accident with military watercraft
W61.12	Struck by macaw
W61.01	Bitten by parrot
V97.33	Sucked into jet engine
X52	Prolonged stay in weightless environment
V96.00	Unspecific balloon accident injuring occupant
V95.40	Unspecific spacecraft accident injuring occupant

without increasing clarity in any aspect (52-55). In addition, multiple manuscripts (56-61) have shown its complexity and a lack of benefits. In fact, a systematic review by Hohl (57) of ICD-10 codes used to identify adverse drug events in administrative data shows substantial variability exists in the methods used. Another manuscript by Drösler et al (56) concluded that 6 to 9 secondary diagnosis fields are inadequate for comparing complication rates using hospital administrative data, recommending that at least 15 and perhaps more with ICD-11 are needed to fully characterize clinical outcomes. This study essentially shows the unreliability and ineffectiveness of ICD-10. Boyd et al (61) has substantiated the complexity of the transition from ICD-9-CM to ICD-10-CM with a thorough quantitative summary per clinical specialty. The complexity (58), discriminatory costs (61), and disruptive conversions (59) have been described.

The ICD-10 system is used only to record increased mortality in 138 WHO member countries and increased morbidity in 99 WHO member countries (42,62,63). This argument is inappropriate as ICD-10, but not ICD-10-CM, has been used in the United States since 1999 to code and classify mortality data from death certificates. In addition, of over 200 countries utilizing ICD-10, only

10 countries employ ICD-10 in the reimbursement process, but not ICD-10-CM, 6 of which have a single-payer health care system including Canada, the United Kingdom, Norway, Sweden, Iceland, and Finland (42). In addition, the Canadian experience has shown that despite a single-payer system and most physicians employed by the hospital system, productivity plummeted and has not recovered thus far since implementation started in 2001.

It has been argued that ICD-10-CM will enhance the ability to measure and to improve health care services, to support disease management programs, to enhance the ability to conduct public health surveillance, to compare data with other countries, and to support a twenty-first century health system (64). While these goals are laudable, they have nothing to do with the billing and reimbursement process and will not improve U.S. health care and realistically, these arguments will always remain as hypothetical. As shown above, only 10 countries employ ICD-10, but not ICD-10-CM, in the reimbursement process, 6 of which entertain a single-payer health care system employing all physicians. Even then they have encountered multiple issues. Grimsley and O'Shea (42) have described that if the goal is to collect data, there are easier and better ways to do so. In fact, a coding system specifically designed to capture

patient data for clinical purposes and facilitate sharing of such data already exists and is called Systematized Nomenclature of Medicine—Clinical Terms (SNOMED CT) (65). Further, many of the accountable care organizations and medical societies continue to develop patient registries, even though they have been declared to be of no value by some. Further, even the report published by HHS, which acknowledged that any benefits that could possibly be derived from ICD-10 implementation would not be realized until at least 10 years after ICD-10-CM implementation (66,67). The proposed and hypothetical benefits of ICD-10 are uncertain and unproven with a high potential for unintended, but devastating, consequences for the health care industry and patients.

Thus, a detailed analysis by multiple organizations and authors have shown a lack of usefulness of updating the clinical data, a lack of improvement in patient care, and devastating consequences.

IMPLEMENTATION COSTS

Despite multiple arguments and the positive aspects that it will increase employment for coders, consultants, and incomes for the HIT industry, implementation costs continue to be staggering. The same arguments have been made before TechBust, HIPAA, Medicare Modernization Act (MMA) regulations, ACA, EHRs and now ICD-10-CM without recognizing that it is not ICD-10. In fact, disasters of EHRs and related implementation standards have highlighted the vast difference between estimations, arguments by tech industry with reality (9-14,68,69). In recent months, it has been published that Duke University and Partners Health Care of Boston have each spent \$700 million to go live in 2014 with EHR systems (11,12,69). This is in contrast to the newly built University Medical Center in New Orleans, which spent \$1.1 billion in construction of a 446-bed teaching hospital (70). Unfortunately, the hospital's opening was postponed, in part, due to a shortage of \$88 million. This hospital construction was controversial even though Charity hospital was old and decaying with numerous structural deficiencies related to Hurricane Katrina. Now, let us compare the \$1.4 billion spent on 2 hospital systems just for an EHR. Further, numerous hospitals across the nation have been heading toward bankruptcy related to financial pressures. Removing the clinical personnel in favor of IT personnel and IT equipment will not only reduce access to care, but also increase costs. Further, the IT industry still lags behind implementation of regulations, since it is un-

regulated and unable to provide software for appropriate intraoperability to implement continuous changes. Mandl and Kohane (68) described the future of health IT and ways to escape the EHR trap. They described that EHR vendors propagate the myth that health IT is qualitatively different from industry and consumer products in order to protect their prices and market share and block new entrants. Consequently, the first priority for Congress is to control and regulate the IT industry. These facts indicate that transition to ICD-10-CM will not only be costly for all health care providers, it will be devastating for smaller independent practices with unforeseen financial and administrative burdens, resulting in productivity losses and reimbursement disruptions having an adverse effect on not only the practices, but the quality and the cost of health care (42).

Implementation costs are skyrocketing, along with reduced patient face-to-face time, costing small practices approximately \$162,000 followed by about \$85,000 in maintenance fees.

The misconception has been that ICD-10 is merely an expansion of ICD-9, with increased specificity; however, in the United States what is proposed is ICD-10-CM, which is a completely new coding system even from ICD-10, with a new structure, new categories, new definitions, and new reimbursement rules (22). In addition, it has been advocated that crosswalk from ICD-9-CM to ICD-10-CM is easy; however, a review of the various codes (17-22) showed only a small percentage of codes convert 1:1. The Canadian experience (22,53,71,72) has illustrated that crosswalks are either not possible or unreliable at best, due to incompatibility between the code sets and different underlying principles, despite a single-payer system and staggered implementation over a period of 5 years.

Preparation of ICD-10-CM for health care providers has become a cottage industry for HIT, consultants, and coders, which requires updating IT systems, allocating substantial amounts of time on behalf of physicians, expensive training, and personnel. Even though it is difficult to accurately define costs to an individual provider or practice, multiple cost estimations have been performed on both sides, more so from the opponents than the proponents. The results of a Nachimson Advisors survey in 2008, which was updated in 2014 (73,74), showed a cost of \$56,639 and \$226,105 for a small group with 3 providers and 2 administrators; \$213,364 and \$824,735 for a medium sized group of 10 providers, one coder, and 6 administrators; and finally between \$2 million to over \$8 million for large groups with 100 pro-

viders and 64 billing staff. A 2006 report from a global management consulting firm showed the cost of ICD-10 implementation for all providers nationwide to be between \$2.52 billion and \$6.67 billion (75). A report from the Nolan Company estimated the implementation costs for all providers to range from \$4.1 billion to \$10.5 billion (71). A survey conducted in 2010 estimated that the total system cost just for health insurance companies may range between \$2 billion and \$3 billion, with the average per member implementation costs ranging from \$38 for small health plans to \$11 for large plans (76). In contrast, a survey conducted by the proponents revealed that in small physician offices the implementation costs are not significant as originally anticipated, and range from \$5,000 to \$10,000 (77). As flawed and inaccurate as this survey is, this study still illustrates significant expenses. Of further concern are the recurrent costs that health care providers will face on a yearly basis, including productivity losses and reimbursement disruptions, which continue to pose barriers to managing an efficient and viable independent practice.

In addition to physicians, nurses also will experience productivity losses and increased investment in coding. Nachimson Advisors estimated that physicians will spend 15% longer working on documentation (74). In addition, coders will likely need to confer with physicians more frequently to select the correct code for a given procedure or diagnosis, increasing the time spent advising coders and documenting medical services, which will result in less time for patient encounters for evaluation, diagnosis, and treatment (78). At present, physicians spend about 22% of their time on nonclinical paperwork, and coding for diagnosis and procedures, which will increase substantially (79).

With increased time, cash disruptions, and declines in reimbursement, most physicians believe that ICD-10-CM will adversely affect health care, and do not support its implementation (80,81). These sentiments were reflected in a 2014 physicians foundation survey with more than 75% of physicians believing that it will needlessly complicate coding, more than 50% believing that it will create severe administrative problems, and 38% believe it will expose physicians to more liability, whereas a mere 11% believe that it will improve diagnosis and quality of care (81).

Nachimson Advisors (73,74) estimated that the potential costs of productivity loss to range from \$8,500 to over \$1.6 million per practice on an annual basis. In addition, the Nolan Company also estimated annual

productivity losses to range from \$300 million to \$400 million for all providers nationwide (71). Thus, the productivity losses among U.S. health care providers is expected to be not only large, but long lasting (52,53,71).

The issues related to reimbursement and cash disruptions are of paramount importance for independent practices. CMS estimated that the denial rate will increase 100% to 200%, in the 2% to 6% range (80-83). The cash disruptions may be short-term or could be long-term. Many practices have been advised to set aside 6 months of cash to cushion the blow of the anticipated cash flow disruption (22). Thus, bankruptcy may be the only option for some, whereas for others borrowing is an option. However, eventually reimbursement disruptions will also adversely affect credit ratings and interest rates, leaving the option of borrowing aside. In addition, CMS has conducted end-to-end testing on 2 occasions in January and June 2015 with the accurate coding rate reaching 88%. However, under extremely controlled circumstances, the failure rate continues to be 12% in the best scenario and may increase to 30%. Further, no such testing is performed by other payers. The potential of disruptions may be heightened from Medicaid being controlled by private insurers and other providers. In addition, it has been also shown that ICD-10-CM will result in a loss of clinically pertinent information that could affect roughly 5% of billing costs (59).

Cash flow disruptions and practice failures may also affect the health care workforce. Many physician practices, specifically the small ones, without time, money, or expertise, to follow and to comply with the mounting regulatory challenges. They may be sold to hospitals or take early retirements (84). This will lead to increased health care market consolidation, which is in part a response to declining reimbursements, increasing operating costs, and increasing administrative burden which has accelerated over the past few years. It has been shown that hospital industry consolidation has increased in 2012 approximately 50-60% after the passage of the ACA compared to 2005 to 2007 (82). However, increased consolidation will also increase health care costs and result in declining productivity with reduced patient quality care and increased cost of care (85).

CONCLUSION

Multiple policies, including ICD-10-CM, threaten the mere existence of independent practices and may lead to the potential demise of personalized medicine.

It can be prevented by Congress with timely action. To combat these forces and to maintain personalized medicine into the future with independent practices, Congress:

1. Must recognize the differences between ICD-9-CM with approximately 13,000 codes and ICD-10 with 14,400 codes which has been expanded to 16,000 codes in some countries utilizing optional sub-classification, with proposed ICD-10-CM for the United States with 144,000 codes not used by any other country.
2. Must recognize the consequences for providers and patients with the potential interruption of services and declining quality due to a reduction in reimbursement, increased administrative burden, and disruption of cash flow
3. Must understand that the basis for conversion to

ICD-10-CM was a liberal interpretation by CMS of an inconspicuous provision in Title II of HIPAA that only authorized an update to ICD-9.

4. Must look beyond ICD-10 with its unnecessary costs and disruptions to ICD-11 to be released by 2017 and change implementation from ICD-9-CM to ICD-11 (86).
5. May delete the ICD system from the reimbursement policy and establish a more appropriate reimbursement process.

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