ICD-10-CM

Plans, Tools, & Resources for Making a Successful, Timely Transition

For the Non-Acute, Ambulatory Practice
Welcome to ICD-10-CM Transition!

This information was written and organized to provide ICD-10 project managers and staff a high level look at everything a physician practice needs to know and do in order to prepare for the ICD-10-CM transition on October 1, 2014.

The information presented offers participants with information and tools on how to assess, plan for, and implement a successful transition including; code structure, clinical documentation assessment and improvement, impacts on revenue, and payer issues. Material covered also includes relationships with trading partners, information systems and technology. In a nutshell-

What you need to know, what you need to do, and how to do it!

Some of the most important ‘take-aways’ will be an understanding of what questions need to be asked in order to assess and prepare for ICD-10 transition. To that end, we’ll cover key questions for your payers and vendors as you proceed with your project plan.

Will this project take time? Yes! Will there bumps in the road as you manage your way through the process? Yes, probably. With proper planning, transition may not be as hard as you might think! The key is to begin. And, since you’re reading this, you already have! Let’s get started...

Jerry Bridge
President, Healthcare Collections & Training

About you speaker...

Jerry Bridge, founder and president of Healthcare Collections & Training and LifeWorks Education is a motivational speaker and educator working for the healthcare industry. Over the past twenty five years Jerry has led programs and workshops for healthcare executives, practice managers and administrative staff on a variety of issues including; billing and collections, customer service and communication, stress and time management, and productivity.

Jerry recently released The ICD-10-CM Transition Planning Guide, a one hundred page project management planner written especially for medical practice managers. You can learn more by visiting www.HealthcareCollections.net or calling 760.918.6701.
Overview

1. **Know the basic facts and benefits of ICD-10**
   - The end of the line for ICD-9
   - Important Facts
   - ICD-10 Code structure & features
   - Benefits

2. **Know the pervasive impacts of ICD-10 on Workflow**
   - Provider-Coder Productivity
   - Superbill
   - Referrals
   - Order Entry
   - Administration

3. **Know how to assess and improve clinical documentation**
   - Specificity
   - Engaging Providers
   - Chart Audit
   - Documentation Tools
   - GEMs/Translation Software

4. **Know how to organize your ICD-10 Project Plan**
   - Project Plan Overview & Checklist
   - Budgeting
   - Staff Training
   - Quarterly Planner

5. **Know how to manage your trading partners & health plans**
   - Practice Management Software
   - Electronic Medical Records
   - Health Plans
   - Billing Service
   - Clearing House
   - End to End Testing

6. **Checklists & Resources**
   - Readiness Checklist
   - Post Transition Checklist
   - Web Resources
   - Code Translators
   - Glossary of Terms
Jump Start to ICD-10-CM Transition!

More than likely, you are behind (according to most national surveys and transition timelines) with your transition. Not to worry! You just need to get started right away – don’t delay!

- These are THE 4 ACTIONS STEPS you should be taking now:

1. **Convert your codes**
   - a. Identify most commonly used ICD-9 Codes
   - b. Translate those codes to ICD-10 using code books, GEMS or Software
   - c. Begin to identify and assess current documentation shortfalls

2. **Engage your providers**
   - a. Conduct chart audits and share the results.
   - b. Give them tools to start documentation improvement – now!

3. **Contact your Vendors:**
   - a. Will they be able to dual code?
   - b. Are there added costs?
   - c. When they will be ready to test?

4. **Begin your Implementation Plan**
   - a. Organize your team
   - c. Using the ‘Training Planner’, schedule needed training
     - Inform your staff about upcoming training
     - Assign tasks with **due dates**

*Schedule weekly meetings to review results, identify challenges, and set goals with due dates.*
Objective 1: Regulatory Background, Facts & Benefits

Regulatory Background
Knowing the regulatory background and requirements gives you a clear picture of the commitment the federal government has made to ICD-10, its place in the future, and why it will happen. It also helps dispel some of the myths surrounding the ICD-10-CM transition.

- 1996 – HIPAA’s “Administrative Simplification”
The intent was to mandate adoption of regulations for privacy, security, unique identifiers and electronic transactions and code sets.

- 2000 – HHS Final Rule
Names standard transactions to be used by covered entities (providers, payers and clearinghouses who conduct specific administrative transactions electronically.)

- January 16, 2009 – HHS Final Rule
Replace inflexible, ambiguous version 4010 electronic format with version 5010 with mandatory use by January 1, 2012. Also...Adopts ICD-10 as the new code set to replace ICD-9-CM with mandatory use by October 1, 2013. (Later delayed to Oct. 1, 2014)

Version 5010
To process ICD-10 claims or other transactions, providers, payers, and vendors must first implement the “Version 5010” electronic health care transaction standards mandated by HIPAA. The existing HIPAA “Version 4010/4010A1” transaction standards do not support the use of the ICD-10 codes.

Everyone covered by HIPAA must install Version 5010 in their practice management or other billing systems and test with all payers and trading partners by January 1, 2012. It is important to know that though 5010 transactions will be in use before October 1, 2013, covered entities are not to use the ICD-10 codes in production (outside of a testing environment) prior to that date.

Note: your organization must coordinate the Version 5010 and ICD-10 implementations to identify affected transactions and systems. For more information on Version 5010, go to the
The ICD-10-CM Transition Workshop

CMS website at [www.cms.gov/ICD10](http://www.cms.gov/ICD10) and click on “Version 5010” on the menu on the left side of the page.

**Background Information**
- ICD-10 was published by WHO in 1990
- U.S. is the last industrialized nation to implement ICD-10 for morbidity reporting (mortality since 1999)
- ICD-10 consists of two parts: ICD-10-CM for diagnosis coding and ICD-10-PCS for inpatient hospital procedure coding
- ICD-10-CM ~ 69,000 codes, ICD-9-CM ~ 13,600 codes
- There are three to seven alpha and numeric digits and full code titles for ICD-10-CM
- October 1, 2014 – ICD-9-CM is no longer acceptable for diagnosis reporting for covered entities under HIPAA

The end of the line for ICD-9!

The ICD-9 code set is over 30 years old and has become outdated. ICD-9 has several limitations that prevent complete and precise coding and billing of health conditions and treatments. In addition, ICD-9 is no longer considered usable for today’s treatment, reporting, and payment processes. The codes do not provide the level of detail necessary to further streamline automated claim processing, which would result in fewer payer-physician inquiries and potential claim payment delays or denials.

➢ An outdated, ‘broken’ coding system

Continuing to use ICD-9 will have an adverse impact on the value of health care data, including the accuracy of decisions based on faulty or imprecise data. For example:

A patient is diagnosed with **acute tonsillitis**, his second diagnoses within 6 months. In ICD-9, acute tonsillitis is reported using ICD-9-CM code 463.

There is no fourth or fifth digit to report the acute condition or the specific organism causing it.
In ICD-10-CM, the code set for tonsillitis is expanded to a **fourth character extension** to identify whether the acute condition is **recurrent** and the **causative organism**, if known.
Important Compliance Dates:

- The last regular annual update to both ICD-9 and ICD-10 code sets was made on October 1, 2011.

- On October 1, 2013, there will be only limited code updates to both ICD-9-CM and ICD-10 code sets to capture new technology and new diseases.

- There are no new or revised or deleted ICD-9-CM diagnosis codes effective for October 1, 2013.

- There will be no updates to ICD-9-CM on October 1, 2014 as the system will no longer be a HIPAA standard. Only limited updates will be made to ICD-10 for new technology and new diseases.

- On Oct. 1, 2015, regular updates to ICD-10 will begin

About ICD-11-CM

- W.H.O. estimated release in 2015
- Clinical Modifications (CM) take years to develop for the U.S. unique payer model (It took 7 years to develop ICD-10-CM plus years to legislatively mandate)
- ICD-9 is 2 years gone and unrecoverable

Transition to ICD-10 is not optional!

- Any ICD-9 codes used in transactions for services or discharges on or after October 1, 2014 will be rejected as non-compliant and the transactions will not be processed. You will have disruptions in your transactions being processed and receipt of your payments.

- You cannot transition before the cutover date. This affects all payers. This will not affect CPT or ADA Dental codes, although dental codes must be 5010 transaction compliant.

- The code changes will have no impact on the existing Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) coding systems for medical procedures.

- CPT and HCPCS (Level II) coding will still be used for physician care; professional services; and procedures performed in a physician's office and outpatient facilities, including hospital outpatient departments.
What’s the real story regarding an increase in number of codes?

- Gastroenterologists: 596 ICD-9 codes and 706 codes in ICD-10 (+110)
- Pulmonologists: 255 codes in ICD-9 and 336 codes in ICD-10 (+81)
- Urologists: 389 codes in ICD-9 and 591 codes in ICD-10 (+202)
- Endocrinologists: 335 codes in ICD-9 and 675 codes in ICD-10 (+340)*
- Neurologists: 459 codes in ICD-9 and 591 codes in ICD-10 (+132)
- Pediatricians: 702 codes in ICD-9 down to 591 codes in ICD-10 (-111)
- Infectious disease: 1,270 in ICD-9 down to 1,056 in ICD-10 (-214)

A few hundred new codes equal a limited number of new documentation elements!

The Overall Coding process is the same:

1. Capture the required encounter documentation
2. Choose the correct code
   - Look up the main term in the Alphabetic index (Scan sub-terms and follow cross-references)
   - Locate the code in the Tabular List (Observe punctuation, cross-reference and other notations)
   - Consult the official guidelines for additional information before assigning the code
3. Make sure you have the medical necessity to justify the procedure or service

➢ Greater specificity requires greater knowledge about translating anatomy and physiology documentation into the code.

Examples of 3 – 7 Character ICD-10-CM Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I10</td>
<td>Hypertension</td>
</tr>
<tr>
<td>M54.6</td>
<td>Pain in thoracic spine</td>
</tr>
<tr>
<td>H65.06</td>
<td>Acute serous otitis media, recurrent, bilateral</td>
</tr>
<tr>
<td>M19.072</td>
<td>Primary osteoarthritis, left ankle and foot</td>
</tr>
<tr>
<td>S72.335A</td>
<td>Nondisplaced oblique fracture of shaft of left femur, initial encounter for closed fracture</td>
</tr>
</tbody>
</table>

➢ Note the higher specificity in the codes above. What does that mean?

Thorough, easily accessible documentation is required to accurately code!


ICD-10 Myths & Facts

**Myth:** “ICD-10-CM implementation planning should be undertaken with the assumption that the Department of Health and Human Services (HHS) will grant an extension beyond the October 1, 2014, compliance date.”

> Fact: All Health Insurance Portability and Accountability Act (HIPAA)-covered entities must implement the new code sets with dates of service, or date of discharge for inpatients, that occur on or after October 1, 2014. **HHS has no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required to implement ICD-10-CM/PCS on October 1, 2014.**

**Myth:** “Non-covered entities such as Workers’ Compensation, disability and auto insurance companies that use ICD-9-CM must implement ICD-10-CM.”

> Fact: **These entities are not required to implement ICD-10.** Because ICD-9-CM will no longer be maintained after ICD-10-CM/PCS is implemented, it is in non-covered entities’ best interest to use the new coding system. The increased detail in ICD-10-CM is of significant value to non-covered entities. The Centers for Medicare & Medicaid Services (CMS) will work with non-covered entities to encourage their use of ICD-10-CM/PCS.

**Myth:** “Physicians who choose their own codes will not have to worry about training as their EHR will do this for them.”

> Fact: Although EHRs are starting to do some great things in regards to prompts, problem lists, and other assistive tools for ICD-10, they do not take the place of required education for those physicians selecting their own codes. **One of the biggest concerns with ICD-10 is driving accurate representation of the severity of our patients' illnesses and hence, the medical necessity of the procedures and tests we will perform.**

If a secondary condition is not on your problem list or you do not have quick access to more specific code choices, the provider may miss out on opportunities to capture this greater specificity and severity of illness leading to possible greater scrutiny.

Documentation education is important because if you do not have the documentation to support the code selected, then you open yourselves up to significant risk.

EHRs are a vital aspect of our transition to ICD-10, but understanding of the core concepts of ICD-10 physician documentation and coding are required to be successful.
ICD-9 & ICD-10-CM Diagnosis Code Format and Differences

<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes</th>
<th>ICD-10-CM diagnosis codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 3-5 characters in length</td>
<td>• 3-7 characters in length</td>
</tr>
<tr>
<td>• Approximately 14,000 codes</td>
<td>• Approximately 69,000 available codes</td>
</tr>
<tr>
<td>• First digit may be alpha (E or V) or numeric; Digits 2-5 are numeric</td>
<td>• Digit one is alpha; Digits two and three are numeric; Digits 4-7 are alpha or numeric</td>
</tr>
<tr>
<td>• Limited space for adding new codes</td>
<td>• Flexible for adding new codes</td>
</tr>
<tr>
<td>• Lacks detail</td>
<td>• Very specific</td>
</tr>
<tr>
<td>• Lacks laterality</td>
<td>• Has laterality</td>
</tr>
<tr>
<td>• Difficult to analyze data due to non-specific codes</td>
<td>• Specificity improves coding accuracy and richness of data for analysis</td>
</tr>
<tr>
<td>• Codes are non-specific and do not adequately define diagnosis needed for medical research</td>
<td>• Detail improves the accuracy of data used for medical research</td>
</tr>
<tr>
<td>• Does not support interoperability because it is not used by other countries</td>
<td>• Supports interoperability and the exchange of health data between other countries and the United States</td>
</tr>
</tbody>
</table>

- The expansion of the codes was done to allow for greater specificity in the coding system. The **first three digits are referred to as the category** and are followed by a decimal point.

![Code Format Comparison](image)

Characters following the three alphanumeric category code:

4th – etiology, 5th - anatomic site, 6th – severity, 7th - extension

- Some codes with six or seven characters may require the use of a dummy **placeholder character** - X - if there is not a 5th or 6th character. When a placeholder applies, it must be used in order for the code to be valid. **Placeholder “X” is not case sensitive.**
  - T15.02xD or T15.02XD – Foreign body in cornea, left eye, subsequent encounter
New Code Features

ICD-10-CM has numerous code features allowing for a greater level of specificity and clinical detail. These include:

Combination codes for conditions and common symptoms or manifestations, poisonings and external causes:

- I25.110, Arteriosclerotic heart disease of native coronary artery with unstable angina pectoris
- K50.013, Crohn’s disease of small intestine with fistula
- K71.51, Toxic liver disease with chronic active hepatitis with ascites
- T39.011, Poisoning by aspirin, accidental (unintentional)
- T39.012, Poisoning by aspirin, intentional self harm

Example:
A patient is being treated by his physician for moderate nonproliferative diabetic retinopathy. The physician documents Type II diabetes with macular edema.

Which combination code below best describes the documentation in the medical record?

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM (select one code from this column)</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.50</td>
<td>E11.311 Type 2 Diabetes with unspecified diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>362.01</td>
<td>E11.321 Type 2 Diabetes with mild nonproliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>362.06</td>
<td>E11.331 Type 2 Diabetes with moderate nonproliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>362.07</td>
<td>E11.341 Type 2 Diabetes with severe nonproliferative diabetic retinopathy with macular edema</td>
</tr>
<tr>
<td>AND</td>
<td>E11.351 Type 2 Diabetes with proliferative diabetic retinopathy with macular edema</td>
</tr>
</tbody>
</table>

Combination codes are also available for external causes and poisonings with information combined into one code (including the drug involved) making difficult sequencing rules obsolete.

Under ICD-9-CM, improper sequencing of primary and secondary diagnosis codes is a common reason for the denial of the claim. Because ICD-10-CM uses combination codes that include secondary manifestations or diagnoses, sequencing is less of a challenge.
Added laterality:

- C50.212, Malignant neoplasm of upper-inner quadrant of left female breast
- H02.835, Dermatochalasis of left lower eyelid
- I80.01, Phlebitis and thrombophlebitis of superficial vessels of right lower extremity
- L89.213, Pressure ulcer of right hip, stage III

Expanded codes; injury, diabetes, alcohol/substance abuse, postoperative complications:

- E08.22, Diabetes mellitus due to an underlying condition with diabetic chronic kidney disease
- E09.52, Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene
- E10.11, Type 1 diabetes mellitus with ketoacidosis with coma
- E11.41, Type 2 diabetes mellitus with diabetic mononeuropathy

Code Extensions (seventh character):

- A Initial encounter
- D Subsequent encounter
- S Sequelae

Example: Laceration with foreign body of abdominal wall, right lower quadrant with penetration into peritoneal cavity, initial encounter, shows an extension used with a laceration code. Note; with ICD-10-CM, the entire code description is written out.

Code S31.623A

External cause codes

- Under the ICD-9-CM coding system, there is no national requirement for the mandatory reporting of external-cause codes, and there also will be no national requirement under ICD-10-CM.

- Also not required is the reporting of the ICD-10-CM codes in Chapter 20, External Causes of Morbidity—unless a provider is subject to a state-based, external-cause code-reporting mandate or a particular payer’s whim. Naturally, if a new state- or payer-based requirement is instituted, that may change. According to CMS, “Such a requirement would be independent of ICD-10-CM implementation.”

- Even if there is no mandatory reporting requirement, CMS encourages providers to voluntarily report external-cause codes because they provide “valuable data for injury research and evaluation of injury-prevention strategies.”
Example: Crushed by an Alligator: Initial encounter (W5803XA) or a subsequent encounter (W5803XS).

- **Signs, Symptoms, and Unspecified Codes**

Use of signs, symptoms, and unspecified codes is “acceptable, even necessary” in both ICD-9-CM and ICD-10-CM. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

*If the provider has not determined a definitive diagnosis by the end of the encounter, codes for sign(s) and/or symptom(s) may be reported.*

When a more specific code can’t be assigned because the clinical information provided isn’t sufficient, the appropriate unspecified code may be used, for example;

‘*A physician determines a diagnosis of pneumonia but not the specific type.*’

- Each healthcare encounter should be coded to the level of certainty known for that encounter.
- Unspecified codes should need to be selected less often due to greater number of code choices in ICD-10-CM.
- Unspecified codes should be reported when they most accurately reflect what is known about the patient’s condition at the time of that particular encounter.
- When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code.
ICD-10 Benefits

Now that you know some of the important ICD-10 facts, an understanding of the benefits of ICD-10 will help to:

- Deepen provider and staff engagement,
- Strengthen and enhance teamwork,
- Provide the groundwork needed for the project planning, education and implementation necessary for a successful ICD-10 transition.

Here are five benefits:

1. The added detail embedded within ICD-10 codes better informs health care providers of patient incidence and history, which improves the effectiveness of case management, care coordination and overall patient care!

2. Streamlining payment operations will allow for greater automation and fewer payer-physician inquiries, decreasing delays and inappropriate denials!

3. The breadth, granularity and specificity of codes which will allow physicians to paint a clear picture, presenting a precise story of the patient’s health!

4. Accurate coding will reduce the volume of rejected claims due to ambiguity!

5. Proper documentation and accurate coding will have a positive impact patient safety, patient outcomes, compliance and the revenue cycle!

Assess & Discuss:
Objective 2: Pervasive Impacts

In every instance where an ICD-9 code currently intersects with your practice there will be impacts with ICD-10. This section presents you with an overview of the impacts on clinical documentation and workflow processes.

“Practices need to realize that ICD-10 goes well beyond simple payer-provider transactions, an easy realization when one thinks about every workflow that touches ICD-9 today.”
Adele Allison, National Director of Government Affairs

In some cases you will find specific recommendations for mitigating those impacts, in other cases you will need to assess and further discuss with your practice team. Here is an overview of the impact areas you should consider:

- Provider-Coder Productivity

You should expect that coder and provider productivity will decrease and the amount of rework will increase about 20 percent with ICD-10. As you move to ICD-10, the provider query process may be challenging with the increased need for specificity. The rate of queries is expected to increase by 55 percent with ICD-10.

“Unprepared practices risk decreasing provider productivity in the last quarter of 2014 as clinicians search for a diagnosis from the 70,000 possible codes. Coding queries between coders and clinicians will skyrocket, further burdening clinical staff and delaying the payment of claims. Incomplete, inaccurate, and incorrectly sequenced diagnosis codes could result in delayed or denied claims.” Betsy Nicoletti Pearls, Coding, Fee Schedule Survey, ICD-10

The increased documentation requirements will increase the amount of time and effort that practices spend on each patient encounter. This is not simply the temporary decrease in productivity due to learning a new code set. This impact will be permanent, and may either require additional staff to provide the documentation, or decrease the number of patients a practice could treat. You’ll want to meet with providers, coders, scheduling staff to assess and discuss in order mitigate this impact on workflow and productivity.

Assess & Discuss:
Superbill

The American Academy of Professional Coders (AAPC) recently issued a comparison between the ICD-9-CM Superbill and what its ICD-10-CM equivalent would look like, based on a template that the American Academy of Family Physicians (AAFP) created.

The template created by the AAFP is about nine pages long and shows 164 ICD-9 diagnosis codes identified by FPM as being those most commonly used by family physicians!

Superbill Solution

1. Since ICD-10 will only affect the diagnosis codes that physicians report, you should focus on converting the top 50 diagnosis codes that your practice currently uses, regardless of specialty.

2. Crosswalk the codes, using GEMS, translation software or code books to ICD-10.

3. Create a template that also includes: E&M codes, Procedure codes, other services such as Radiology, Injections, and DME etc.

Example: In ICD-9 there are 16 codes for Asthma. There are 36 codes for Asthma in ICD-10. Rather than listing all 36 codes, try listing the Code Block along with the new required elements of documentation.

<table>
<thead>
<tr>
<th>Asthma: Category Code J45</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncomplicated</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Moderate, Persistent, Uncomplicated = Code Choice J45.40**

Coordination Issues with Other Providers

Getting a diagnosis code from an ordering or referring physician, and the necessary associated documentation, is another issue you will need to deal with. Experience has shown that not all practices keep up with necessary changes. Any lack of information from ordering or referring physicians will delay payment for the receiving practice.

Incomplete or insufficient diagnostic information at the point of ordering will potentially delay scheduling and registration processes, overall coding processes, increase the volume of queries to the ordering physician, increase overall billing cycle time, overall Accounts
Receivable (A/R) Days, and potentially result in medical necessity questions and increased denials.

➢ **Referrals**

*Providers that both send and receive patients for referral will need to upgrade their requests and reports for ICD-10-CM.* Communicating in a common code “language” will minimize misunderstandings and accurately portray both the reason for the referral and the resulting findings. It is recommended you **meet with your most frequently referred-to and referred-from providers** in order to establish a clear process for reporting the corresponding code set for that payer. Consider converting commonly referred-out and referred-in diagnoses using GEMs or your code books and share the code conversion with your clinical partners. Not all practices will be as prepared as you are.

➢ **X Rays, Labs & Order PT, OT, DME Orders**

Proper clinical documentation to support detailed coding in the physician orders is a must. **You will need a diagnosis code in order to describe what you need tested or filmed and to meet medical necessity.** Therefore, paper and electronic requests need to be updated in order to indicate the proper ICD-10-CM code and not the old ICD-9-CM code. Additionally, ICD-10-CM training will need to be conducted for any staff member that submits a lab or radiography (X-ray, MRI, CAT) order. This will most likely include ancillary staff.

Just as with Lab or X-ray order entry above, you will need an ICD-10-CM code to describe the condition for which you are ordering physical/occupational therapy and durable medical equipment. Request forms therefore need to be updated and training needs to occur for those affected by this change.

➢ **Update Forms**

*Hard copy and digital order forms and processes must be upgraded for ICD-10-CM.* If you do not coordinate the ICD-10-CM transition with your ancillary providers for the above, you will not be able communicate your request. Collect and review these processes and update to ICD-10-CM where required. Use either GEMs or a code book to help familiarize your staff. During the transition, they will be able to tell the difference between a 5 digit ICD-9 code and up to a 7 character alphanumeric code.

Ancillary providers will require very specific codes from you to be able to be reimbursed for their services. Set up a plan to meet these providers and communicate the required codes. Make sure all providers and staff has access to these prior to ordering services or you will be fielding lots of phone calls asking about alternate codes.
Pay for Performance (P4P)

Under ICD-10-CM, P4P measures that are based on ICD-9-CM diagnosis codes will be forced to change, necessitating a review and possible changes in treatment. It will take considerable time for measures to be developed and vetted by the industry. Many are concerned that these measures may not be able to be developed for some time after ICD-10-CM is being used, to permit longer-term clinical usage prior to identification. If prior measures are being used based on ICD-9-CM codes, practices will be forced to ascertain how the ICD-10-CM codes are being tracked back to ICD-9-CM codes.

Recommendation

If your providers are being measured based on diagnosis coding, the measurements must be adjusted to account for the new ICD-10-CM codes. Work with the performance measuring entities (both internal and external) to ensure ICD-10-CM readiness. Use GEMs or your code books to convert your reporting codes.

Reporting

More than likely, your practice will need to create reports to review various diagnostic data; utilization, frequency, and quality. In order to produce these reports, all of the diagnosis codes may need to be crosswalked to either ICD-9 or ICD-10. The direction that you crosswalk the data will depend on how much of the data is in one code set or the other.

Recommendation

If you are running a report for calendar year 2014, the majority of the diagnosis codes will have been coded in ICD-9. It will be easier to crosswalk the ICD-10 codes back to ICD-9 in order to compare all of the data together. If you are doing a 12-month review of data in July 2014, it will be easier to crosswalk the ICD-9 codes forward to ICD-10.

Pharmacy

Your prescription process must be updated for use of the new ICD-10-CM. The use of ePrescribe will take care of the majority of your transition requirements. Review this process with your pharmacies.

As with paper prescriptions, all electronic prescriptions for controlled substances are required to contain the full name and address of the patient, drug name, strength, dosage form, and quantity, prescribed directions for use, and the name, address and registration number of the practitioner. The prescription shall be dated as of the day when signed and shall be signed by the practitioner using his/her two-factor authentication credential.
Where applicable, refill information must also be included, as well as any other information required by DEA regulations.

**Administrative Services**

Insurance verification, pre-authorization or pre-certification for insurance coverage and possibly surgery scheduling will have to be updated for the new ICD-10-CM codes. Not only must your request processes be updated, your staff also needs to be trained in order to ensure a smooth transition.

You’ll need to make sure reception and billing staff is trained;

- What do they do with ICD-9 codes?
- How do they do it?
- How will they be affected by ICD-10?

**Patient Education**

Practices have direct contact with patients on a daily basis, and it is expected that they will have to explain to patients why, in some cases, additional tests, discussions, and procedures are necessary to justify a particular treatment protocol.

Practices may have to develop written material that assists in explaining what changes have been made, why they were made, and also what changes patients may see in their EOBs from health plans. Coverage changes may also need to be explained to patients. Some changes to patient registration.

Assess & Discuss:

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________________________________________________________________________
________________________________________________________________________
Objective 3: Clinical Documentation- Assessment & Improvement

Educating providers on clinical documentation is as crucial as it is delicate. Physicians need a range of human and technological support to guide them to the documentation needed for the increased specificity of ICD-10-CM. There are multiple reasons that the documentation in the record may not be specific enough.

Providers can perceive their documentation as clear in its intent. However, they may be missing critical documentation needed for coding. Physicians are taught medicine during their education; documentation is not necessarily a part of their medical curriculum.

*For example, the physician may state that “the patient was grunting,” often meaning the patient was in acute respiratory failure. However, a coder cannot assume a diagnosis using such a general term. There is a difference in acuity by stating the disease more specifically.*

It is also critical for providers to clearly understand the need for greater specificity and granularity in documentation in order to obtain optimal reimbursement, quality data for reporting, and greater accuracy in showing the level of care provided.

*If the diagnosis code is invalid you will most likely not get paid!*

> “Physicians may be compliant, but if they abuse the “other” or “unspecified” codes, payment will not occur if a more specific alternative exists.” David Winkler, Director of Program Management, Blue Cross of Michigan

Your practice should start by reviewing current medical record documentation on the most frequently-coded/billed conditions. To prepare for ICD-10, they should ask;

- “How does current documentation stack up to ICD-10-CM standards?”
- “What changes can be implemented now to start preparing for ICD-10?”

Drills can be done now to prepare for the conversion to ICD-10, such as facilitate coding audits and exercises so staff becomes familiar with the changes. Additionally, staff should query physicians to gather the most appropriate information to assign the code with the highest level of specificity.

*It is critical that you begin identifying documentation improvement opportunities and make necessary changes to business processes, including medical record documentation and coding. When it comes to ICD-10, early preparation is the key to a successful and seamless transition.*
**Documentation Highlights**

- Nearly 25 percent of the ICD-10-CM codes are the same except for laterality: indicating the right side of the patient’s body versus the left.
- Another 25 percent of the codes differ only in the way they distinguish among “initial encounter,” versus “subsequent encounter,” versus “sequelae.”
- Even though there are more than 1,800 available codes for coding fractures of the radius, there are only approximately 50 distinct recurring concepts.

There are four elements necessary for accurate and efficient orthopedic coding in ICD-10: location, laterality, type of fracture and type of visit. As you can see below, the required information is eight additional words:

<table>
<thead>
<tr>
<th>ICD-9 CM</th>
<th>ICD-10 CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>822.0 Patella Fracture, closed</td>
<td>S82.025A Nondisplaced longitudinal fracture of left patella, initial encounter for closed fracture</td>
</tr>
</tbody>
</table>

The table below shows the type of documentation the ICD-10-CM will require for a fracture of the radius.

- **Category:** The category for the medical concepts that will need documentation
- **Documentation Requirements:** The list of individual concepts that should be considered in documentation to support accurate coding of the patient conditions

**Type I diabetes mellitus with diabetic nephropathy**

➢ **First** - Look up term in Alphabetic Index:
  Diabetes, diabetic (mellitus) (sugar) E11.9
  Type 1 E10.9
  with
  Nephropathy E10.21

➢ **Second** - Verify code in Tabular:
E10 Type 1 diabetes mellitus
  E10.2 Type 1 diabetes mellitus with kidney complications
  E10.21 Type 1 diabetes mellitus with diabetic nephropathy
  Type 1 diabetes mellitus with intercapillary glomerulosclerosis
  Type 1 diabetes mellitus with intracapillary glomerulonephrosis
  Type 1 diabetes mellitus with Kimmelstiel-Wilson disease

**Code Assignment: E10.21**
Engaging your providers

Now is the time to start engaging and educating your physicians on ICD-10. Your training sessions do not have to be long, exhaustive, or have intensive material to review; start small and continually build upon your previous sessions.

Providers do not need to know the finite details of how the ICD-10 coding system works, nor should they focus on the number of codes. CDI training should focus on the importance of complete and proper documentation and their role in producing it.

The primary role for providers in ICD-10 implementation is that of a student: they should be focused on receiving the proper education related to accurate documentation in a timely way to assure that appropriate testing occurs prior to implementation.

A useful approach to take for engaging and helping your providers improve documentation is to be positive and project confidence. You may want to deliver a short and simple slide presentation on ICD-10 awareness at the medical staff meeting.

- Tailor your training plan and education as much as possible—you may want to begin with a high-level, basic overview explaining ICD-10; how it is an improvement over ICD-9, the new structure, how it ties into other projects within your organization (meaningful use, Accountable Care Organizations, etc.) and when it will be implemented.

- Have a prepared agenda! When training and educating physicians on ICD-10 make sure you are clear with what the training sessions will cover.

- Avoid confusion by having and following a documented training plan— are we discussing laterality or severity? This will keep all parties on track and allow for standardization of training to ensure nothing gets missed or inadvertently skipped over.

- Be as specific as possible and zero in on your subject matter so as not to confuse or overwhelm your physicians. Again, be prepared and organized so you won’t waste the physician’s time, or your own.

- Review how the codes in their specialty have been improved upon, are more granular and consist of greater specificity.
Chart Audits

In order to properly assess your provider’s current level of documentation you’ll need to conduct chart audits. This will help you—and your providers—understand where documentation gaps exist so you can educate accordingly. It’s important to understand that you do not need to be a coder to do this!

1) Make a list your top 20 to 30 diagnoses; sort by provider, revenue, & frequency.
2) Translate the codes used in those diagnoses to ICD 10. You can do this using code books, GEMs, or translation software (See GEMS & Translation Software)
3) Retrieve the patient charts containing those ICD 9 diagnoses
4) Assess whether the current documentation will support the future ICD-10 code choice by looking to see if the required elements of documentation (the words) are present in the record.

<table>
<thead>
<tr>
<th>Chart</th>
<th>Patient ID</th>
<th>Documented Diagnosis (description)</th>
<th>ICD-9-CM Diagnosis Documented</th>
<th>ICD-10-CM diagnosis options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A1234</td>
<td>Unspecified Mastoiditis</td>
<td>383.8</td>
<td>H70.891 H70.892 H70.893 H70.899 Depends on related conditions, site J11.00 J12.9 Depends on identification of virus</td>
</tr>
<tr>
<td>2</td>
<td>00ABC</td>
<td>Influenza w/pneumonia</td>
<td>487.00</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>QXYZ1</td>
<td>Chronic Hypertension w/o complications</td>
<td>459.30</td>
<td>I87.309</td>
</tr>
</tbody>
</table>

Physician Name: Chris Davis, MD
Reviewer (Auditor): Joy Todd, CPC
Date of Audit: 08/26/2013
Number of medical records reviews month of August 2013: 12
Number of medical records documented the appropriate ICD-9-CM code: 100%
Number of medical records support documentation for ICD-10-CM: 30%
Number of medical records lacking documentation specificity to support ICD-10-CM: 70%
Review the results and highlight the positives!

No one wants to hear what they are doing wrong and how much extra work they will have to do. Trumpet their successes—if they have been consistently documenting laterality or an underlying condition, highlight that and let them know it is correct and to keep up the good work! Recognize what is already accurate within their notes, focus on what they don’t have to change and then thoughtfully build in what needs to be updated.

➢ More Documentation Highlights

Laterality: ICD-10-CM introduces laterality to diagnosis coding. Many providers already document which side of the body the disease or injury occurred, but it is now a required data element with ICD-10-CM.

- Examples include M25.561 (Pain in right knee) and S52.521 (Torus fracture of lower end of right radius).

Combination codes: ICD-10-CM also greatly expands the use of combination codes, where a single code is used to classify two diagnoses or a diagnosis with an associated secondary process or complication. This relationship cannot be assumed or inferred; the documentation must clearly state the relationship.

- Examples include spondylosis with radiculopathy, hypertension with heart disease, and osteoporosis with current fracture.

Episode of care: ICD-10-CM relies more heavily on categorizing the episode of care for injuries and illnesses. Fractures in particular are required to indicate if the injury is the initial or subsequent encounter.

- Examples include S42.411D (Displaced simple supracondylar fracture without inercondylar fracture of right humerus [subsequent encounter with routine healing]) and S80.01xA (Contusion of right knee [initial encounter]).

Greater specificity: ICD-10-CM is much more specific in identifying diseases and conditions and the documentation will need to reflect the exact diagnosis to take advantage of the improved granularity.

- For example, instead of stating simply “dysphagia” as the impression for a barium swallowing study, providers should document the following codes: R13.11 (Dysphagia, oral phase), R13.12 (Dysphagia, oropharyngeal phase), R13.13 (Dysphagia, pharyngeal phase), or R13.14 (Dysphagia, pharyngoesophageal phase).
Provider Coding Tools
Offer tools to help your providers understand and begin capturing the new documentation requirements under ICD-10. This process is similar to the Chart Audit, with a few important additions:

1) Start by list of your top 100 most frequently used ICD-9-CM diagnosis codes
2) Translate the ICD-9 codes to ICD-10 using the GEMs mapping tool or translation software.
3) For each code, highlight unique documentation and coding requirements
4) Create simple tools, one per root code; flash cards, notes or reminders

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Asthma</th>
<th>ICD-10</th>
<th>New Documentation Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>493.00</td>
<td>Extrinsic asthma, unspecified</td>
<td>J45.20</td>
<td>Mild intermittent asthma, uncomplicated</td>
</tr>
<tr>
<td>493.01</td>
<td>Extrinsic asthma with status asthmaticus</td>
<td>J45.22</td>
<td>Mild intermittent asthma with status asthmaticus</td>
</tr>
<tr>
<td>493.02</td>
<td>Extrinsic asthma with (acute) exacerbation</td>
<td>J45.21</td>
<td>Mild intermittent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>493.10</td>
<td>Intrinsic asthma, unspecified</td>
<td>J45.20</td>
<td>Mild intermittent asthma, uncomplicated</td>
</tr>
<tr>
<td>493.11</td>
<td>Intrinsic asthma, with status asthmaticus</td>
<td>J45.22</td>
<td>Mild intermittent asthma with status asthmaticus</td>
</tr>
<tr>
<td>493.12</td>
<td>Intrinsic asthma, with (acute) exacerbation</td>
<td>J45.21</td>
<td>Mild intermittent asthma with (acute) exacerbation</td>
</tr>
</tbody>
</table>

Smartphone Apps

There are numerous ICD-10 Smartphone apps designed to prepare coders, physicians, nurses, case managers, administrative staff and other populations for the transition to ICD-10.

Making education available at any time and any place is the key to driving utilization and retention and delivering value to the learner and organization.

- ICD-10 Doc Talk - listen to specialty-specific audio webinars designed to provide an overview of the impact ICD-10 will have on each specialty.
• **ICD-10 Flash Cards** - interactive app offers more than 25 decks and more than 1,000 individual flash cards that allow the user to practice and test their knowledge and memory of ICD-10 concepts, terms, definitions and guidelines that will be required for ICD-10 mastery.

**GEMS “General Equivalence Mappings”**

Created and developed by The National Center for Health Statistics (NCHS) the GEMs are considered to be the authoritative source for crosswalking between ICD-10 and ICD-9. The GEMs are data files and list the ICD-9 and ICD-10 codes and the attributes of the mapping between the two code sets.

There is a file for mapping from ICD-10 to ICD-9 and another for mapping from ICD-9 to ICD-10. Mapping from ICD-9 to ICD-10 is called “forward mapping” and mapping from ICD-10 to ICD-9 is “backward mapping.”

The GEMs are intended to serve as tools for activities such as implementing ICD-10 and analyzing data that spans the conversion time period. **The GEMs files will not be maintained on an ongoing basis after the ICD-10 compliance date has passed.** The ICD-9 code set will no longer be updated after October 1, 2012.

Crosswalking between the code sets will assist you with identifying the differences between ICD-9 and ICD-10. Crosswalking can assist you with coding assessment, and the creation documentation tools, new encounter forms or superbills.

**The GEMs are not an exact crosswalk between the code sets.** An exact one-to-one matching of the ICD-9 and ICD-10 codes cannot occur due to the changes in structure and concepts in ICD-10. Percentages of types of code matches:

- 5% of ICD-10 codes match exactly to ICD-9 codes
- 24% of the ICD-9 codes match exactly to an ICD-10 code.
- 49% of the codes have one-to-one approximate matches
- 19% of the matches are one-to-one with multiple choices, requiring further review to determine the appropriate approximate match.

**Crosswalking is not a substitute for learning and fully implementing ICD-10 into your practice.**

There is information that can be lost or gained when ICD-9 and ICD-10 codes are crosswalked to one another. Just like when translating between English and a foreign language, there are situations where the meaning of words are not exact and convey different ideas. Not using the diagnosis code that most accurately represents the patient’s condition will impact the integrity of the data.
The GEMs are available for free and can be accessed from many sources:

- NCHS: [www.cdc.gov/nchs/icd/icd10cm.htm](http://www.cdc.gov/nchs/icd/icd10cm.htm)
- Find-A-Code: [www.findacode.com](http://www.findacode.com)
- American Hospital Association: [www.ahacentraloffice.org](http://www.ahacentraloffice.org)

**Diagnosis Code Mapping**

**One-to-One**

<table>
<thead>
<tr>
<th>ICD-9-CM Source</th>
<th>ICD-10-CM Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>783.21 Loss of Weight</td>
<td>R63.4 Abnormal Weight Loss</td>
</tr>
</tbody>
</table>

**One-to-Two**

<table>
<thead>
<tr>
<th>ICD-9-CM Source</th>
<th>ICD-10-CM Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>784.2 Swelling in head and neck</td>
<td>R22.0 Localized swelling, mass or lump head R22.1 Localized swelling, mass or lump neck</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10-CM Source</th>
<th>ICD-9-CM Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>R65.21 Severe sepsis with septic shock</td>
<td>995.92 Severe Sepsis, AND 785.52 Septic Shock</td>
</tr>
</tbody>
</table>

**One-to-Three**

<table>
<thead>
<tr>
<th>ICD-9-CM Source</th>
<th>ICD-10-CM Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>692.73 Acute Dermatitis due to solar radiation</td>
<td>L56.0 Drug phototoxic response L56.1 Drug photo allergic response L56.2 Photo contact dermatitis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10-CM Source</th>
<th>ICD-9-CM Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>E08.52 Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene</td>
<td>251.8 Other specified disorder of the pancreatic internal secretion 443.89 Other specified peripheral vascular disease 785.4 Gangrene</td>
</tr>
</tbody>
</table>

**One-to-Zero**

<table>
<thead>
<tr>
<th>ICD-10-CM Source</th>
<th>ICD-9-CM Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>R40.2133 – Coma scale, eyes open to sound at hospital admission</td>
<td>None</td>
</tr>
</tbody>
</table>

*The message for physicians is that their job in the ICD-10 transition is not learning the 69,000+ new codes. It is learning the elements of documentation required to be able to select specific ICD-10 codes.*
Objective 4: Project Management & Planning

Because ICD-10 will impact all aspects of your practice, it is essential to have your entire team in place to guide the work. Your team should include representatives from both the clinical and business sides of the practice, to make sure each perspective is represented.

Your first priority should be to assess, create and assign the tasks that must be completed in order to successfully transition to ICD-10. It should provide high-level information that informs and coordinates all efforts, and should consider important factors such as timelines, resources and budget. To get you started, here’s a project plan, overview, and checklist.

Identify a project leader & form a team:
- Billing
- Compliance
- Finance
- Revenue Cycle Management
- Information Technology

Develop a project plan
- Assessing the impact of implementation
- Implementing goals and timelines
- Education and training
- Budget

Develop a master list of vendors; EHR, PM, billing services & clearinghouses
- Contact vendors to determine when upgrades to ICD-10 will be available
- Determine who pays for the upgrade
- Determine whether the upgrade is covered under your existing maintenance agreement
- Develop a testing strategy for each vendor

Prepare a list of largest health plans (by volume)
- Contact and schedule meetings with health plans to review how reimbursement will be impacted by ICD-10
- Determine if the health plan is converting existing contracts to ICD-10 or if a new contract is required
- Identify special terms in your contract to cover special edits, testing support, etc.
- Determine which ICD-9 codes are used to establish reimbursement
- Discuss whether the health plan is using the Center for Medicare and Medicaid Services (CMS) GEMs map to convert to ICD-10 or a custom map.
- Host periodic follow-up meetings with the health plan to share implementation progress and to validate future plans for testing
Implementation
- Providers & Clinical documentation
- ‘End to End’ Testing
- Coders Trained/Certified
- Workflows & Productivity

➤ Budgeting

The AMA reported that the average physician practice that has adopted an EHR may spend up to 80 thousand dollars ($80K) to implement ICD-10 and those that have not adopted an EHR, up to two-hundred fifty thousand dollars ($250K) to implement ICD-10.

“Practices that are on the financial bubble currently may not survive this transition. The key is to begin planning early and not to underestimate the size and scope of the organizational ICD-10 education needs.” Annie Boynton, director ICD-10 Adoption & Training, UnitedHealth Group

In Developing an ICD-10-CM implementation budget, you should consider:
- Software Purchases & Upgrades
- Hardware: New Servers & Workstations
- EMR: Purchase and/or upgrade costs
- Implementation: Staff Training & Overtime
- Staff training costs, overtime expenses
- Forms: Superbills, Labs. etc
- End to End Testing costs

A report by Nachimson Advisors, a health care strategic planning firm, estimates the expenses accruing to various aspects of the adaptation to ICD-10 as follows for a “typical” practice:

<table>
<thead>
<tr>
<th>Expense</th>
<th>Small: 3 Providers &amp; 2 administrative staff</th>
<th>Medium: 10 Providers, 1 full time coder, 6 administrative staff</th>
<th>Large: 100 providers, 64 coders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff education and training</td>
<td>$2,405</td>
<td>$4,745</td>
<td>$46,280</td>
</tr>
<tr>
<td>Business process analysis</td>
<td>$6,905</td>
<td>$12,000</td>
<td>$48,000</td>
</tr>
<tr>
<td>Changes to forms</td>
<td>$2,985</td>
<td>$9,950</td>
<td>$99,500</td>
</tr>
<tr>
<td>IT costs</td>
<td>$7,500</td>
<td>$15,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Increased documentation</td>
<td>$44,000</td>
<td>$178,500</td>
<td>$1.76 million</td>
</tr>
<tr>
<td>Cash flow disruption</td>
<td>$19,500</td>
<td>$178,500</td>
<td>$650,000</td>
</tr>
<tr>
<td>Total</td>
<td>$83,295</td>
<td>$398,695</td>
<td>$2,703,780</td>
</tr>
</tbody>
</table>
Staff Training: Needs & Schedule

Staff should be educated based on **specific roles and needs**. Your training may be varied based on the user’s current level of knowledge and experience with ICD-10. Training should include:

- Regulatory Overview
- ICD-10 Overview /Guidelines
- ICD-10 CM Code Set
- Software/Workflow/Process Changes

Training methods; match training methods with staff’s needs and learning styles:

- Web-based Training
- Interactive Distance Learning
- Classroom based or Hands -On Instruction
- Ensure that the training resources and methods fit into the training budget

Time Frame: When the training will be delivered?

- ICD-10 Awareness-Immediately!
- Workflow/Process/Coding **6-9 months** prior to the go live date.
- Code Training- Suggested start for **coding training is 6-12 months** prior to go live date.
- You may need to schedule ‘refresher’ trainings as needed.

Monitor your training for effectiveness:

- Measure productivity: Have providers and coders begin using ICD-10 codes along with ICD- 9 to ensure complete documentation and understanding
- Measure outcomes: Continual testing of providers and coders on coding and documentation to uncover any knowledge deficits and ensure there is time to provide supplemental learning.

Recommended Time allowance:

- Awareness: All Employees, 2 hours
- Understanding: Codified data users, physicians, those who reference codes, 4-6 hours
- Proficiency: Employees who assign ICD-10 codes, 20-30 hours
- Power User: Designated Trainer(s) for ICD-10, 80 hours
Objective 5: Software, Vendors & Health Plans

➢ Practice Management Software
For the practice management system, software modifications will be necessary in these critical areas:
- Insurance coverage
- Billing system
- Electronic transactions for eligibility
- Pre-authorizations

Software changes will also impact the business flow of the office, necessitating modifications and subsequent training for clinicians and administrative staff.

➢ Electronic Medical Record Software
An efficient, user-practice friendly EHR can go a long way towards making a smooth transition. It is important to determine –NOW- how your existing EMR will handle ICD-10.

Consider the following features as requirements for your EMR:
- Certified EHR
- Vendor Stability and Commitment
- Verifying that the product is being enhanced and improved
- Usability
- Clinical Content
- Technology Base
- Online Help and Assistance

EMR’s have a wide range of features and capabilities to address the clinical and operational needs of your practice. Focusing on the key issues will help you select an appropriate product without getting distracted into areas that may confuse your process and, in the worst cases, lead to an inappropriate decision.

Some of the important questions to ask software vendors:
- Will the practice be required to purchase any additional hardware or software to support the changes, fixes and enhancements for the ICD-10 releases?
- Describe the support processes and procedures for ICD-10 testing and activation?
- Expected Delivery Date?
- Testing Date?
- Will the upgrade delete existing user customizations?
- How long will the vendor provide support for ICD-9?
- What type of provider clinical documentation enhancements will be made to ensure providers capture additional documentation required for ICD-10?
Health Plans

Health plans may make in their coverage of procedures, therefore it will also be necessary to set up the appropriate matching between diagnosis codes and procedures. Because the new codes will be alphanumeric and take up to seven character spaces, and the logic of how they are used will need to be accounted for, the fields of software programs must change.

This also applies to clinics or software vendors that currently contain ICD-9 codes. With little more than a year to go (as of this writing) you need to call your software vendors and ask what they are doing to insure a smooth transition.

Contact the payers that you submit to as you transition to ICD-10.

- Engage in periodic contract re-negotiations,
- Payer policies and CPT code relative value units (RVUs) change frequently
- One of the most important questions is, “Which codes will the payers recognize?”
- Review those claims that have not been reimbursed by the payer. Oftentimes, there is a specific diagnosis codes tied to the payer’s medical necessity and/or policy denials.
- Your clearinghouse can help you gather this data by service and by payer, so you can gain a better understanding of potential areas of revenue loss.

Medicare will probably make local carrier determinations (LCDs) for most specialties available by October 2013. These LCDs may list the ICD-10 codes private payers will use to come up with their list codes that meet the definition of medical necessity.

Dates of Service

Here’s the general rule: If the date of service (DOS) was before the October 1, 2014, implementation deadline, use the ICD-9 diagnosis code; if it is after October 1, use the ICD-10 diagnosis code.

However, depending upon your payer, you may not be able to use ICD-9 and ICD-10 codes on the same claim. You may have to submit two claims: one with the ICD-9 diagnosis codes and another with the ICD-10 diagnosis codes. Commonly asked questions;

“How do I report ICD-10 codes on claims when the dates of service span from prior to 10/1/2014 to on or after 10/1/2014?”

Many payers are requiring claims with dates of service that span the October 1, 2014 implementation date to be split so that the services prior to 10/1/2014 are billed separately and utilize ICD-9 codes; services on and after 10/1/2014 are billed separately and utilize ICD-10 codes.
“If I submit or process a transaction with an ICD-9 code for a date of service after October 1, 2014, am I HIPAA compliant?”

Once again, the **date of service** determines the compliant code format to be used in a claim regardless of the date the claim is filed or submitted. Providers will submit claims after October 1, 2014 with ICD-9 codes when the services were performed prior to October 1, 2014. Payers will process claims if received after October 1, 2014 with ICD-9 codes when the services were performed prior to October 1, 2014. This situation is HIPAA compliant.

“How long after the October 1, 2014 ICD-10 compliance date must I continue to report and/or process ICD-9 codes?”

Each payer determines their late filing requirements for standard transactions and ICD-10 does not require a change to these requirements. These deadline requirements vary among plans. Contact your payer for the current information regarding late filing for claims.

- **Billing Service & Clearinghouse**
  Under a move to ICD-10, your practice will also have to assure that your billing service and clearinghouse vendors are prepared to process ICD-10 codes. As we have seen with the protracted implementation of the HIPAA electronic transactions, 5010 and national provider identifier (NPI), this is a critical compliance area.

  With far more stringent documentation requirements for ICD-10, billing services and clearinghouses will be forced to send claims back to the practices for resubmission if the original claim does not contain sufficient supporting documentation. The result of this process could be massive delays in claims payment and cash flow problems for practices!

- **Hardware**
  More than likely your practice will require system upgrades possibly in multiple phases—which will take time and money. With the increased number of codes you will more than likely need more storage capacity as well as new servers and/or workstations. Be sure to include these costs in your ICD-10 Budget.

- **End To End Testing**
  In a recent survey conducted of 1,200 MGMA members (representing 50,000 physicians) most reported that they need to upgrade or replace their electronic health record systems (EHRs) and practice management software to accommodate the ICD-10 codes.
  When asked when they expect to test internally, the answers were not good:

  - 45 percent said they hadn’t even heard from their vendors
  - 35 percent hoped to test between January and October 2014.
  - Vendors have not supplied specific dates.
• Health plans and clearinghouses are also are lagging behind: 60 percent of the respondents haven’t heard anything about when their clearinghouses would accept test claims, and 71 percent don’t know when their major health plans would begin testing.

Unique Testing Challenges

The purpose for ICD-10 external testing is far more wide ranging than the HIPAA 5010 implementation. ICD-10 testing requires collaboration between payers and providers to identify and mitigate potential risk areas, including:

• Incorrect, partial, or invalid ICD-10 coding
• Potential claim processing variations between providers and payers due to the selected ICD-10 codes applied to the benefit plan and/or medical payment policies
• Each provider-payer processing path is unique and may branch to multiple paths based on provider or payer systems, intermediary services, product lines, etc

Because of the huge number of partners and process combinations, it is not feasible for most organizations to test with all business partners in the chain - providers, payers, vendor systems, intermediaries and clearinghouses.

**CMS has announced that it will not be doing end to end testing. Commercial carriers are likely to follow suit!**

Testing Resources

The **ICD-10 National Testing Program** is a full scale collaborative testing platform for healthcare. It provides an open and transparent process for healthcare organizations of all types and sizes to test with their trading partners for ICD-10 coding, compliance and reimbursement testing.

To request more information or to enroll in the National Testing Program please email us at **questions@nationaltestingprogram.com**

The Healthcare Information and Management Systems Society (HIMMS) suggest **VitalVendors** as a viable tool to help assess your vendors ICD-10 readiness. VitalVendors is a real-time online report card allowing ICD-10 vendors to self-report their readiness for achieving ICD-10 compliance.
Final Readiness Checklist

Workflow & Business Processes

- Impact assessment completed?
- Chart audits conducted, reviewed and discussed?
- ICD-10 coding resources update, acquired?
- Codes most frequently used; identified, crosswalked?

Training

- Documentation training for physicians organized and managed?
- Coding training?
- Physicians?
- Coders?
- Billers?
- Non-physician clinical staff?
- Ancillary Staff?

Hardware-Software

- Is hardware sufficient to handle the increased data load?
- Can software accommodate both ICD 9 and ICD 10 during and after the transition?

Budgeting-Finance

- Taken into account decreased productivity post transition?
- Secured Lines of credit?

Payers

- Are your top-revenue-producing insurance plans transitioning to ICD-10?
- Will they meet the Oct. 1, 2014 deadline?
- Do you have a list of those payers who will NOT be transitioning to ICD-10 on Oct. 1, 2014?
- Have contract negotiations been completed for plans tying reimbursement to ICD 10?
Jump Start to ICD-10-CM Transition!

More than likely, you are behind (according to most national surveys and transition timelines) with your transition. Not to worry! You just need to get started right away – don’t delay!

➢ These are THE 4 ACTIONS STEPS you should be taking now:

5. **Convert your codes**
   a. Identify most commonly used ICD-9 Codes
   b. Translate those codes to ICD-10 using code books, GEMS or Software
   c. Begin to identify and assess current documentation shortfalls

6. **Engage your providers**
   a. Conduct chart audits and share the results.
   b. Give them tools to start documentation improvement – now!

7. **Contact your Vendors**:  
   a. Will they be able to dual code?  
   b. Are there added costs?  
   c. When they will be ready to test?

8. **Begin your Implementation Plan**
   a. Organize your team
   c. Using the ‘Training Planner’, schedule needed training
      - Inform your staff about upcoming training
      - Assign tasks with due dates

*Schedule weekly meetings to review results, identify challenges, and set goals with due dates.*
Post Transition

It is not possible to know right now, exactly what will happen to productivity and revenue after the transition date on October 1, 2014. Therefore, you will want to keep a watchful eye on productivity, payers and revenue!

By doing so, you may be able to mitigate potential problems early on. Here are some of the critical areas to monitor:

Reimbursement
  o Is there a drop in reimbursement levels?
  o Which payers?
  o Does the denial report indicate lack of medical necessity?

Coding accuracy
  o Does the denial report indicate improper coding?
  o If so, is more coding required?

Prompt Payment
  o Monitor timely payment
  o Be prepared to file appeals for timely payment, down coding & medical necessity

Other Important Metrics to Monitor
  o Total Revenue,
  o Revenue by Payer,
  o Provider Productivity,
  o Denial reports
Web Resources
- CMS: http://www.cms.gov/Medicare/Coding/ICD10/
- AMA: http://www.ama-assn.org
- AHIMA: http://www.ahima.org/icd10/
- AAPC: http://www.aapc.com/icd-10/
- AHA: http://www.ahacentraloffice.org/
- HIMSS: http://www.himss.org
- WHO: http://www.who.int/

ICD-10 Code Translators
- Complete Practice Resources: http://www.cpticdpros.com/lifeworks/
- AAPC: http://www.aapc.com/icd-10/codes/
- ICD-10 Data.com: http://www.icd10data.com/Convert
- Blue Cross/Blue Shield of Hawaii:
- Clinic Service: http://www.clinicservice.com/icd-10-code-translator-tool
The ICD-10 Transition
Practice Manager Planning Guide

Organized and designed specifically for practice-project managers responsible for ICD-10-CM implementation. With this no-nonsense, easy to use guidebook - you’ll learn exactly what you need to know, do, and how to do it!

Your ICD-10 Planning Guide includes:

✓ The 4 critical action steps you should be taking now!
✓ ICD-10-CM ‘Project Planner’: broken down by quarter with action steps!
✓ Best practices for engaging your providers & staff!
✓ Tools to help providers improve documentation, NOW!
✓ ‘Vendor Tracker & Query Forms’ keep your vendors on track!
✓ Recommendations and resources on how to conduct End to End testing!

ICD-10 Planning Guide $399

With Code Translation Software: Convert ICD-9 codes to ICD-10 in seconds! Features multiple code lookups, print capabilities, ability to save favorites and create flash cards. Create training tools for your entire staff, accessible anywhere, from any computer!

Planning Guide with Code Translation Software, Only $599

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