ICD-9 to ICD-10 Shift: Strategies and Steps to Successful Transition

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Objectives

- Explain what happened in April 2014 and how the landscape looks for ICD-10

- Provide a brief overview of ICD-10 to allay fears and realize where the concerns may lie

- Discuss a transition strategy to optimize chances for success

- Relay the importance of clinically correct coding

First.........Education

- Clinicians, CDI teams need education
  - Failure to educate will lead to increased anxiety and angst
    - "Does anyone here know what is going on?"
  - On again/off again ICD 10 roll-out
- There is global ignorance of what this is and how it may affect physicians and healthcare systems (providers)
  - Amplification of the number of new diagnosis and other codes to be used
  - Billing concerns and how that plays into these decisions

Second………April 2014 update

- Congressional action, end March
  - *Protecting Access to Medicare Act of 2014*
    - Halted a 24% pay cut to physicians via the SGR, continued the 0.5% raise and froze for one year
    - Had a stipulation to delay the 2 MN rule
    - Pushed back the ICD-10 rollout to no earlier than 10-2015
      - ICD concerns: "end to end testing" by CMS

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      - ICD concerns: "end to end testing" by CMS
  - President signed next day…April Fools Day

The concern…..

- Roll-out failure would mean global financial failure for the American healthcare system
  - Hospitals
  - Physician group practices
  - Ambulatory Diagnostic Centers
  - Related industries to the above
- Even with the new date of 10-2015, AMA and others are still concerned with this undertaking

The concern…..

- Healthcare providers (hospitals and groups) were set for 10-2014
  - Wasted time and $$
  - Vendor EMR roll-outs were already under contract…no return of monies, time, energy…..?
- Big projects get canned all of the time…but put on hold…..for an indefinite period of time….?

So…..

- After being told in January of 2009, this was to go live 10-**2013**, it did not happen
- Now, after being told repeatedly "no more delays" and will go live in 10-2014 ……it was again delayed.
- Now the "go live" date is 10-2015
- Or, is it……..?

- The Healthcare Family feels burdened…

☹

The MAC's plans for testing

- Inadequate in 03-2014
  - Now, two types in play
- Acknowledgement testing
  - Limited to checks to see if the claims go through the MAC's "front door"
    - November of 2014, March and July of 2015
      - Initial test earlier this year was ~90-99% clean on first run
- "End-to-end" testing
  - Follows claim from submission through to the receipt of the remittance advice.
    - Much more detailed and will give providers info on how the claims payment process will function
    - Scheduled to be done in January, April, and July 2015

Strategy for Success

- Education and Communication
- Process and Plans for Implementation

Education and Communication

- Physician and Staff needs differ
  - Physician needs differ
    - Inpatient only physicians
    - Outpatient only physicians
    - Blended practice physicians
  - Staff needs differ
    - Coding, billing staff
    - Support staff (RNs, ancillary outpatient staff)
- Background education needs to be shared for all
  - Need a foundation of understanding

International Classification of Diseases (ICD)

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- Since 1900, the ICD has been modified about once every 10 years, except for the 20-year interval between the last two revisions, ICD-9 and ICD-10.

Designation	Years in Effect
ICD-1	1900-1909
ICD-2	1910-1920
ICD-3	1921-1929
ICD-4	1930-1938
ICD-5	1939-1948
ICD-6	1949-1957
ICD-7	1958-1967
ICDA-8 (adapted*)	1968-1978
ICD-9	1979-1998
ICD-10	1999-

Other Countries are ahead of US

Year Implemented ICD-10

- United Kingdom   1995
- France   1997
- Australia   1998
- Belgium   1999
- Germany   2000
- Canada   2001
- United States   2013…2014…2015(?)

Educational basics

- The ICD-10-CM, ICD-10-PCS, and the CPT
  - "CM" is the clinical modification and is used to report diagnoses in all clinical settings, both inpatient and outpatient places of service
  - "PCS" is the procedure code set that will be used to report hospital inpatient procedures only
- The "CPT" codes are the current procedural terminology codes and will continue to be used to report services and procedures in the outpatient and office settings
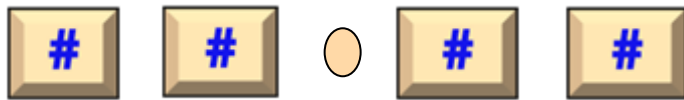
ICD-10-PCS

- Developed by 3M for CMS
- First version was released in 1998
- Replaces about *3,000* ICD-9-CM Volume 3 codes with about *80,000* ICD-10 PCS codes
- No WHO procedure code set – <u>unique to U.S.</u>
- Only used for hospital inpatient coding – does not replace CPT in the outpatient settings

ICD-10-PCS Code Use and Structure

- The ICD-10-PCS codes are for use only on hospital claims for inpatient procedures.

- These codes differ from the ICD-9-CM procedure codes in that they have 7 characters that can be either alpha (non-case sensitive) or numeric.

- The numbers 0 - 9 are used (letters O and I are not used to avoid confusion with numbers 0 and 1), and they do not contain decimals.

ICD-10-PCS (procedures)

- ICD-9-CM (procedures)

[#] [#] ○ [#] [#]

- ICD-10-PCS (procedures)

[a/#] [a/#] [a/#] [a/#] [a/#] [a/#] [a/#]

0FB03ZX - Excision of liver, percutaneous approach, diagnostic

0DQ10ZZ - Repair, upper esophagus, open approach

Section, Body System, Root Operation, Body Part, Approach, Device, Qualifier

ICD "CM": Not just morbidity and mortality…

- The international standard classification for
  - General epidemiological info
  - Health management purposes
  - Clinical uses
    - Population health management
    - Disease prevalence
    - Quality metrics
    - Reimbursement/resource allocation
- Documentation of the encounter is how we translate the clinical picture into code sets
  - Translation is difficult with ICD-9 at times

ICD-9-CM Basics

- ICD-9-CM has 3 – 5 digits
- Chapters 1 – 17: all characters are numeric
- Supplemental chapters: first digit is alpha (E or V), remainder are numeric
- Examples:
  - 496 Chronic airway obstruction not elsewhere classified (NEC)
  - 511.9 Unspecified pleural effusion
  - V02.61 Hepatitis B carrier

ICD-9 CM... Providers, Do You Know?

- Code for benign essential hypertension?
- Code for unspecified essential hypertension?
- ...for malignant essential hypertension?
  - ...from a pheochromocytoma?
- What about CHF?
- ...benign hypertensive heart disease w CHF?
- What about chest pain?
- ...chest wall pain?
- ...chest pain with breathing?

ICD-9 CM…Did You Know?

- Code for benign essential hypertension? **401.1**
- Code for unspecified essential hypertension? **401.9**
- …for malignant essential hypertension? **401.0**
    - …from a pheochromocytoma? **405.99**
- What about CHF? **428.0**
- …benign hypertensive heart disease w CHF? **402.11**
- What about chest pain? **786.50**
- …chest wall pain? **786.51**
- …chest pain with breathing? **786.52**

- **How did you do….?**

ICD-9-CM is Outdated

- 30+ years old –technology has changed
- Many categories full
- Not descriptive enough
    - Research limitations
    - Payment limitations
- Unable to compare across countries

ICD-9 and ICD -10 Differences

	ICD-9	ICD-10
Diagnosis	13,000	
Procedure	3,800	
Codes	3-5 characters in length, mostly numbers	
Flexibility	Limited space for adding new codes	
Specificity	Lacks detail	

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Flexibility	Limited space for adding new codes	Flexible for adding new codes
Specificity	Lacks detail	Very specific

ICD-9 CM and ICD -10 CM Differences

○ ICD-10 CM codes are alpha-numeric, as opposed to primarily numeric in ICD-9

- Malignant neoplasm, upper third esophagus   C15.3
- Malignant neoplasm, upper third esophagus   150.3

- Essential (primary) hypertension   I10.
- Unspecified essential hypertension   401.9

- Acute tonsillitis   J03
- Acute tonsillitis   463

ICD-9 CM and ICD -10 CM Differences

- ICD-10 CM codes are alpha-numeric, as opposed to primarily numeric in ICD-9
- ICD-10 CM codes contain up to a maximum of 7 characters, as opposed to the 5 characters seen in ICD-9
- Late effects are handled differently
  - Late effects (ICD-9) are referred to as *sequela* (ICD-10) and these events are noted with the addition of an additional digit to address the condition that caused the sequela

ICD-9 CM and ICD -10 CM Differences

- ICD-9 has 17 chapters, ICD-10 has 21
  - ICD-10 has separate chapters for eye/adnexa and ear/mastoid
  - There is an ICD-10 chapter 22, but it is not used for international data comparison and therefore this chapter is not included in the ICD-10 CM for the US
- The "External Cause" codes (V and E codes) for ICD-9 are not "supplemental" in ICD-10 as they have their own chapters (20,21)
- ICD-10 codes are organized differently that in ICD-9
  - Sense organs have been separated from nervous system disorders
  - Post-operative complications have been moved to procedure-specific body system chapter
  - Injuries are grouped by anatomical site, not by injury category

Injury Changes

- ICD-9-CM
  - Fractures (800-829)
  - Dislocations (830-839)
  - Sprains and strains (840-848)
- ICD-10-CM
  - Injuries to the head (S00-S09)
  - Injuries to the neck (S10-S19)
  - Injuries to the thorax (S20-S29)

Example:

- **fracture of wrist:**
    - Patient fractures left wrist
    - A month later, fractures right wrist
    - ICD-9-CM does not identify left versus right – **requires additional documentation**

    - ICD-10-CM describes left versus right
    - Initial encounter, subsequent encounter
    - Routine healing, delayed healing, nonunion, or malunion

ICD-10-CM Diagnosis Codes

- Characters 1-3 – Category

- Example:

ICD-10-CM Diagnosis Codes

- Characters 1-3 – Category

- Example:
  - **S52** Fracture of forearm

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ICD-10-CM Diagnosis Codes

- Characters 1-3 – Category
- Characters 4-6 – Anatomic site, severity, etiology, or other clinical detail

- Example:
    - **S52** Fracture of forearm
    - **S52.5** Fracture of lower end of radius
    - **S52.52** Torus fracture of lower end of radius
    - **S52.521** Torus fracture of lower end of right radius

ICD-10-CM Diagnosis Codes

- Characters 1-3 – Category
- Characters 4-6 – Anatomic site, severity, etiology, or other clinical detail
- Characters 7 – Extension (initial visit, subsequent, etc.)
- Example:
  - **S52** Fracture of forearm
  - **S52.5** Fracture of lower end of radius
  - **S52.52** Torus fracture of lower end of radius
  - **S52.521** Torus fracture of lower end of right radius

ICD-10-CM Diagnosis Codes

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- Example:
  - **S52** Fracture of forearm
  - **S52.5** Fracture of lower end of radius
  - **S52.52** Torus fracture of lower end of radius
  - **S52.521** Torus fracture of lower end of right radius
  - **S52.521A** Torus fracture of lower end of right radius, initial encounter for closed fracture

The 7th Character

- 7th character used in certain chapters (e.g., Obstetrics, Injury, Musculoskeletal, and External Cause chapters)
- Different meaning depending on section where it is being used
- Must always be used in the 7th character position
- When 7th character applies, codes missing 7th character are invalid

7th Character Defined

- **Initial encounter**: As long as patient is receiving active treatment for the condition.
  - Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.
- **Subsequent encounter**: After patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
  - Examples of subsequent care are: cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.
- **Sequela**: Complications or conditions that arise as a direct result of a condition (e.g., scar formation after a burn).

Note: For aftercare of injury, assign acute injury code with 7th character for subsequent encounter.

7th character in fractures

- A   Initial encounter for closed fracture
- B   Initial encounter for open fracture
- D   Subsequent encounter for fracture with routine healing
- G   Subsequent encounter for fracture with delayed healing
- K   Subsequent encounter for fracture with nonunion
- P   Subsequent encounter for fracture with malunion
- S   Sequela

Cardiac: Capture severity

- 67 year old seen for atrial fibrillation. Bursts of paroxysmal a-fib have been noted on recent holter. He is symptomatic. Several medication adjustments have been made and you have seen the patient 4 times this month.

Cardiac

- Atrial fibrillation   427.31

- Atrial flutter   427.32

Cardiac

- Atrial fibrillation   427.31
  - Paroxysmal atrial fibrillation   I48.0
  - Persistent atrial fibrillation   I48.1
  - Chronic atrial fibrillation   I48.2
  - Unspecified atrial fib   I48.91
- Atrial flutter   427.32
  - Typical atrial flutter   I48.3
  - Atypical atrial flutter   I48.4
  - Unspecified atrial flutter   I48.92

"X" Marks the Spot

- Addition of dummy placeholder "X" (or "x") is used in certain codes to:
  - Allow for future expansion
  - Fill out empty characters when a code contains fewer than 6 characters and a 7th character applies

When placeholder character applies, it must be used in order for the code to be valid

"X" is not case-sensitive

- T46.1**x**5A or   T46.1**X**5A are both OK to use
    - Adverse effect of calcium-channel blockers, initial encounter
- T15.02**x**D or T15.02**X**D
    - Foreign body in cornea, left eye, subsequent encounter

Make Note: Underdosing

- Underdosing is a new code in ICD-10
- It identifies situations in which a patient has taken less of a medication than prescribed by the physician
  - Non-compliance codes available
  - Complication of care
- May be a way for physicians to show a difficult to treat population
  - "T" code set (T36-T50) and is specific to the medication

Make Note: Unspecified

- If documentation doesn't support more specific codes, coders may code "unspecified"

  -↓Severity and risk scores

  -↓Reimbursement

  - Medical Necessity issues can arise
    - Non/Un-specified disease code doesn't merit as frequent of follow-up
      - Diabetes Mellitus

Combination Codes

- ICD-10's greater specificity also allows comorbid conditions to be combined
    - 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

Complication Coding

- Limited in ICD-9
- For "complications of foreign body accidently left in body cavity following a procedure" ICD-10 has 50 different codes
    - ICD-9 has one
    - T81.530   Perforation due to foreign body accidently left in body following surgical operation

General Equivalency Mapping

- Maps should not be used to assign codes to report on claims
- GEMs and Reimbursement Mappings are not a substitute for learning how to use ICD-10-CM/PCS
- Mapping does not equal coding
    - Mapping links concepts in 2 code sets without consideration of context or medical record documentation
    - Coding involves assignment of most appropriate codes based on medical record documentation and applicable coding rules/guidelines – GEM is not a substitute for correct coding
- GEM: www.cdc.gov/nchs/icd/icd10cm.htm

- *My favorite:* ICD10data.com is a place to start

GEM may not be answer

- Healthcare intelligence software
  - Data mines claims and produces DRG options and looks at ICD-9 → ICD-10 permutations and transitions
    - Groups together to get best DRG option possible
    - Some ICD-9 codes will translate into multiple ICD-10
    - Some ICD-9 codes will not be found in ICD-10
    - Some ICD-9 will be found in combination codes

Cost estimates

ICD-10 implementation

- Areas of cost concern
  1. Education of physicians and staff
  2. Process analysis for needed flow change
  3. Modification of code sets to paper tracking/superbills
  4. IT upgrades
     - 29 different applications at SRHS that must be enhanced
  5. Increased documentation issues
  6. Cash flow slow-down due to slowness of system to pay and appeals/denials

Physician education

- Asynchronous options need to be offered
  - Face to face with an on-line option
  - Point of care need educational tips, flyers, handouts
- Differing needs: Gap analysis to find the 90% group of diagnoses so you can direct education efforts
  - Surgical
    - Read the ICD-10-PCS examples, make sure documentation is there to meet them
  - Medical/Surgical inpatient
    - With documentation, "tell the story to capture the clinical picture"
      - ICD 10 cursory audit → "passed, but we had to look"
  - Medical/Surgical outpatient
    - Most concerning area for transition
    - Support staff is the most lacking here in medical groups

Physician education

- Medical/Surgical Outpatient
  - Gap analysis with focus on codes that generate 90% revenue for practice
    - Some suggest top 20 ICD-9 codes. Depends on specialty
  - Take diagnoses of focus and outline the needs for documentation to fully capture the info related to these codes
    - Procedural documentation make up (wounds)
    - Medical necessity issues surrounding procedures (recent CMS transmittals, send notes to hospital to support)
    - Disease specific education relating to the documentation needs to capture clinically correct coding
- Physicians out of compliance may benefit from a peer to peer ICD 10 dialogue

Support staff education

- RNs, etc. need baseline education and specialty specific education, especially if they assist in code capture or charging
- Billing/coding
  - In depth educational needs here
  - Didactic course with post session testing to show mastery of subject
  - On going training in specialty field and interim auditing to assure compliance

Closing: ancillary staff

- Prolonged, intense education
    - Didactic classroom for billers/auditors
    - Dual coding (ICD-9 and ICD-10) and subsequent audits of their work to show gaps
    - Less intense, but still global education for other staff (physician nurse, ancillary staff)
- Specialty specific I-10 emphasis
    - Become to the physician the expert to assist with I-10 diagnosis code selection
- Updates, yearly review

Closing: the physician piece is key

- Education is key to gain buy in
  - Acknowledge/accept momentum loss
  - Specialty specific, so Physician Champions are needed
  - Asynchronous is a must with options for f/u (call in)
  - All avenues of "educational touch" to cover the gamut of learning (including reference handouts)
- Inpatient strategies: "tell a great story with detail"
- Outpatient strategies: more resources are usually needed to support this effort
  - Careful for "bad data in" and still get paid
  - Crosswalks, staff support key for this situation
  - Be "clinically correct" to capture "risk"

Thanks!!

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