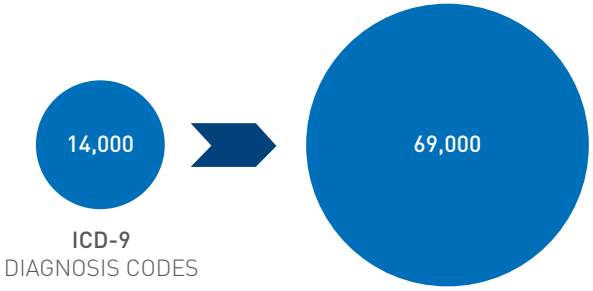
NUMBER OF CODES



ICD-9
DIAGNOSIS CODES

ICD-10
DIAGNOSIS CODES

CODE STRUCTURE

ICD-9-CM CODE FORMAT

XXX • XX

CATEGORY — ETIOLOGY, ANATOMIC SITE, MANIFESTATION

3 TO 5 CHARACTERS
FIRST DIGIT IS NUMERIC OR **E** OR **V**
ALL OTHER DIGITS ARE NUMERIC

ICD-10-CM CODE FORMAT

XXX • XXX • X

CATEGORY — ETIOLOGY, ANATOMIC SITE, MANIFESTATION — EXTENSION

1 TO 7 CHARACTERS
FIRST DIGIT IS ALPHA
ALL DIGITS EXCEPT SECOND ALPHA OR NUMERIC

ICD-10 HISTORY

- **1979** — ICD-9-CM ADOPTED FOR HOSPITAL USE
- **1988** — ICD-9-CM ADOPTED FOR PHYSICIAN USE
- **1994** — WORLD HEALTH ORGANIZATION ADOPTS ICD-10
- **1996** — HIPAA LEGISLATION INTERRUPTS US ICD-10 ADOPTION
- **2008** — CMS PROPOSED RULE TO ADOPT ICD-10 OCT 2011
- **2009** — CMS FINAL RULE TO ADOPT ICD-10 OCT 2013
- **2013** — CMS DELAYS IMPLEMENTATION ONE YEAR
- **2014** — CONGRESS DELAYS IMPLEMENTATION ONE YEAR
- **2015** — **IMPLEMENTATION OCTOBER 1**

ICD-10
Impact and Benefits

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AT A GLANCE:

ICD-10 Impacts:
- Physicians
- Coders
- Billers/billing companies
- Payers

Planning Now is necessary to prevent issues in the fall

ICD-10 benefits will be substantial in the longer term

SUMMARY

Although the implementation of ICD-10 has been delayed several times and there is proposed legislation for another delay, most observers expect ICD-10 to be implemented as scheduled, on October 1 of this year—which isn't far away!

Moving to the new code set will affect every aspect of how your practice or department operates, from referrals and orders, registration (if applicable) to software upgrades (in some cases) and, especially clinical documentation. With October around the corner, the magnitude of the impacts means that practices and departments must have a plan in place by now. Our companion **ICD-10 Implementation Plan for Physicians** outlines the key components.

In this whitepaper, we provide more specifics on the impacts as an aid to your planning efforts. We conclude with a discussion of the **benefits of ICD-10** because, while the transition requires substantial work, the benefits are expected to be more than worth the effort. For example, greater specificity will allow much better tracking and analysis of clinical conditions and outcomes as well as fewer requests for additional information during the billing process.

At the end, we provide more background on ICD-10.

ICD-10 IMPACTS

ICD-10 will impact:
- Physician documentation
- Physician orders
- Financials
- Coding
- Billers and billing companies
- Payers (insurance companies)

PHYSICIAN DOCUMENTATION

In general, physician documentation will need to be more specific and detailed than is required for ICD-9 coding. That said, physicians with good documentation habits will find the transition much easier than those who currently use abbreviations or other shortcuts. Since ICD-10 codes are more precise, physicians will need to provide comprehensive documentation so that coders can select the correct diagnosis code(s). This may mean capturing new information about the patient's condition that the physician never documented before or updating, modifying and expanding his/her documentation.

Physicians must be aware that falling back on unspecified codes is not acceptable and if they continue to use the "other" or "unspecified" codes, payment may not be made if a more specific code exists. Here are some examples that require more specific physician documentation:

For **injury coding**, the following eight criteria should be documented in order to code properly.

- Type of encounter (initial or subsequent)
- Applied specificity (did the patient lose consciousness?)
- Acute versus chronic
- Relief or non-relief (intractable versus non-intractable)
- External cause (what caused the accident?)
- Activity (what was the patient doing when he/she was injured?)
- Location (where was the patient when he/she was injured?)
- Size and depth of injury
- Dominant vs. nondominant side – required for injuries of the nervous system

Drug underdosing is a new code in ICD-10 which identifies situations in which a patient has taken less of a medication than prescribed by the physician. To code this, the medical condition is sequenced first, the underdosing code is listed as a secondary diagnosis, and an additional code explains why the patient is not taking the medication (e.g., financial reasons). Since this is a new code requirement, many physicians will not be in the habit of documenting a patient's reason for under-dosing in the medical record.[1]

Combination Codes: ICD-10 contains some combination codes so documentation must reflect the association between conditions. For example, ICD-10 code K50.814 designates "Crohn's disease of both small and large intestine with abscess. The ICD-9 equivalent codes would be 555.2 – regional enteritis, small intestine with large intestine and 569.5 – Abscess of intestine.

Hospital-based specialists will still continue to use CPT codes for outpatient procedures but their documentation must be detailed enough to support the ability of the hospital to assign ICD-10-PCS coding for inpatient services. *Note: ICD-10-PCS coding will not replace CPT coding for physicians but is intended to identify inpatient facility services in a way not directly related to physician work but directed towards allocation of hospital services. CPT remains the procedure coding standard for physicians, regardless of whether the physician services are provided in an inpatient or outpatient setting.*

Reporting Diagnoses: Medical and public record templates, forms, superbills, etc., will need to be reviewed and revised to capture the most-used ICD-10 codes. Many physicians use superbills or EHR templates with pre-assigned diagnosis codes for their most commonly seen conditions; this can speed up reporting the physician's services for billing. But superbills or templates can limit the number of codes that are available for selection and can cause the physician to bill codes that are not supported by actual medical record documentation. With the increased number and specificity of ICD-10 codes, it has been suggested that coding from medical documentation may be in the physician's best interest.[2]

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[1] Newsletter from the NCHICA ICD-10 Task Force, "Clinical Documentation Challenges with ICD-10-CM, November 2011
[2] Kuehn, Lynn, MS, "Preparing for ICD-10-CM in Physician Practices"

If superbills or templates are used, they should be carefully re-coded with ICD-10 codes.

Mapping of common ICD-9 codes to their ICD-10 "equivalents" is available on the AdvantEdge website and in specialty-specific resource guides, available from your AdvantEdge Client Manager or Sales contact.

PHYSICIAN ORDERS

Much of the information needed for diagnosis coding by a specialist (e.g. radiologist, pathologist, etc.) must come from the referring physician, and with ICD-10 coding, the amount of information required from the referring physician increases dramatically. To be certain the clinical reason for each request is properly and thoroughly documented in the order may require both enhancement of a physician's intake protocols and education of referring physicians.

Failure of referring physicians to supply the needed information may cause delayed or lost reimbursement to the specialist. As a result, specialists have a vested interest in helping their referring physicians provide proper documentation. Specialists should now be communicating with their highest volume referring physicians about their plans and training for ICD-10 documentation

FINANCIALS

In theory, ICD-10 should not impact physician cash flow. In practice, as seen in the ANSI-5010 transition, disruptions in cash flow are possible, if not likely, during the ICD-10 transition.

In addition, significant transition costs will arise from staff training, reduced productivity while adapting to the new codes, software upgrades and possible delayed revenue due to payer issues.

There are opportunities for some free training, but in most cases fees for training and time away from regular duties will add to the transition cost. At a minimum, the documentation and coding processes may take longer or create a backlog resulting in reduced productivity and interrupted cash flow, at least in the beginning.

Providers must also ensure that all systems (EHR, practice management systems, RIS or other platforms) affected by ICD-10 have been updated to accept and use the new codes—while still running parallel ICD-9 codes for diagnoses on services before October 1. Many computer system components or modules use ICD-9-CM as part of their logic. Examples are patient problem lists, appointment or preventive intervention alerts, system interfaces or standard reports. These systems must be changed to also include ICD-10 codes.

More problematic is the likelihood that some payers won't be ready and will therefore delay payments. As discussed in the Insurance Carrier section below, some insurance carriers may crosswalk ICD-10 codes back to ICD-9 codes for payment purposes which could create opportunities for confusion and claim processing errors.

"Industry skeptics have voiced concerns about possible mischief and intentional denials surrounding this policy. Therefore, it would be wise for physician groups to include ICD-10 in their payer contract negotiation discussions to decrease risks concerning compliance errors and claim denials."[3]

[3] Stone, David, "ICD-10 Challenges Physicians to Analyze Business Processes and Communication," May 2, 2011.

CODING

Not only are there many more codes in ICD-10 (69,000 with 3-7 digits vs 14,000 with 3-5 digits), but ICD-10 is more complex than ICD-9, breaking diagnosis codes down to a much finer level of granularity. For one extreme example, diabetes was a single code under ICD-9. Now there are 50 codes associated with the disease. Here is CMS' version of the relationship between ICD-9 and ICD-10 codes.

- 49.1%—Approximate Match
- 24.2%—Exact Match
- 18.7%—1 Match with Multiple Choices
- 3.0%—No Mapping
- 2.9%—Complex Mapping
- 2.1%—1 to Many

Source: Centers for Medicare & Medicaid Services (CMS) General Equivalence Mapping (GEMs). Based on 2011 GEMS mapping.

ICD-10 also uses a different hierarchy and approach. This means that coders, including physicians who assign diagnosis codes, must learn a new system. Among other requirements, this new system requires much more anatomic specificity, so that coders should have already completed their anatomic training.

Here are several of the top documentation changes.[4]

Laterality – the side of the body where injury or diagnosis has occurred will have to be documented including diagnoses such as injuries, arthritis, cerebral infarction, pressure ulcers, cancers, arthritis.

Stage of Care – The seventh digit of the ICD-10 code will indicate the stage of care the physician rendered; whether initial or subsequent.

Example:

- Clinical indication: Follow-up to check fracture healing
- Impression: Healing, internally reduced right supracondylar fracture
- ICD-10 Code: S42.411D – displaced simple supracondylar fracture without intercondylar fracture of right humerous (subsequent encounter with routine healing)

Specific diagnosis – documentation needs to reflect the exact diagnosis so a coder can take it to the closest code level.

Example: Rather than reporting "dysphagia" as the impression for a barium swallow study, the following codes are available:

- R13.11 – dysphagia, oral phase
- R13.12 – dysphagia, oropharyngeal phase
- R13.13 – dysphagia, pharyngeal phase
- R13.14 – dysphagia, pharyngoesophageal phase

Specific anatomy – Many ICD-10 codes are very specific in terms of anatomy and providers must document this level of specificity.

Example: For degenerative changes of the spine (code M47, sponylosis), document the exact level, Options are: occipito-atlanto-axcial, cervical, cervicothoracic, thoracic, thoracolumbar, lumbar, lumbosacral, sacral and sacrococcygeal

[4] Stoner, Jean, " The Top 10 Documentation Tips for ICD-10-CM: The Devil is in the Details," August 25, 2010

Old final impression: Degenerative changes
New final impression: Degenerative changes along the lumbar spine
ICD-10 Code: M47.816 – spondylosis without myelopathy or radiculopathy, lumbar region
Associated related conditions – document conditions that are related or casual. A coder cannot assume a relationship, so the physician must clearly state it.

Some examples:

- Osteoporosis with current fracture
- Pleural effusion with heart failure
- Spondylosis with radiculopathy
- Hypertension with heart disease
- Hypertension with chronic kidney disease
- Hypertension with heart and chronic kidney disease

Clinical indication: Low back pain and history of compression fracture and osteoporposis
Final Impression: T12 compression fracture
ICD-10 Codes: M80.08xA – age-related osteoporosis with current pathological fracture, vertebra(e), initial encounter, and Z87.310 – personal history of healed osteoporosis fracture

BILLERS AND BILLING COMPANIES

By now, billing systems should be updated to handle ICD-10 codes, and do so in parallel with ICD-9 codes. This is because outpatient and office claims with service dates after the effective cutover date must be submitted with ICD-10 while all earlier claims require ICD-9. In the case of inpatients, the discharge date determines which code will be used. Rebilled claims will use the same coding as the original claim. Adding to this complexity, billing systems need to be able to accept both ICD-9-CM and ICD-10-CM codes for a period of time since non-HIPAA-covered organizations such as Workers Compensation and automobile insurance companies are not required to move to ICD-10. Claims to these organizations must be coded and submitted using ICD-9 codes until they switch to ICD-10.

Preparing and testing billing systems is a large effort, given that each payer has its own interface technology. Clearinghouses can help with some of this transition but only to a certain extent. For example, in the case of 5010, clearinghouses insulated physicians from some of the payers who did not cut over to 5010 on time. However, this resulted in conversion of 5010 information to 4010 format, losing information not carried in both formats. The same situation is likely to arise for ICD-10.

CMS MACs, clearinghouses and major commercial payers have established test schedules during 2015. It is essential that your system(s) participate. If you use a billing service, they will conduct the testing and provide feedback based on the results.

In addition to assuring that coding staff is trained and certified on ICD-10, billing staff needs to be trained on the new ICD-10 codes for purposes of reporting, tracking and A/R follow-up. This will be particularly important early in the cutover so that claims denied for ICD-10 related reasons can be quickly evaluated, appealed and resolved.

In April, CMS added the **new Remittance Advice Remark Code (RARC) N742** on their remittance advices (RAs), *"Alert: This claim was processed based on one or more ICD-9 codes. The transition to ICD-10 is required by October 1, 2015, for health care providers, health plans, and clearinghouses. More information can be found at http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html."*

CODERS

Due to the clinical specificity of the new code sets, coders will need additional training to not only learn the new code sets but to assure they have an in-depth knowledge of anatomy, physiology and medical procedures. All certified coders will be required to take an ICD-10 exam in order to keep their certification.

CMS and the CDC, with collaboration from other organizations, developed the General Equivalence Mappings (GEM) as a tool to assist with the conversion from ICD-9-CM codes to ICD-10-CM codes and vice versa. GEMS are also referred to as crosswalks since they provide linking codes from one system with codes in the other system. In some instances, there is not a translation between an ICD-9 and an ICD-10 code and when this occurs, a "No Map" flag indicator is noted.

The AAPC says that because the guidelines, rules, and organization of codes are very similar to ICD-9, anyone who is qualified to code ICD-9-CM should be able to easily make the transition to ICD-10-CM.[5] CMS states that 16 hours of ICD-10-CM training will likely be adequate for most coders, and very proficient coders may not need that much.[6]

However, coding productivity in the first 3-6 month period is expected to decrease as coders adjust to the new methodology, which in turn may delay billing and receipts for a short time.

INSURANCE CARRIERS

Carriers need to review payment policies as this transition will involve new coding rules, some of which will result in new system matches for CPT and diagnosis codes, which can determine whether services will be covered and paid for.

Some insurance carriers have indicated they will "crosswalk" ICD-10 codes back to ICD-9 codes and vice versa for payment purposes, which allows them to avoid expensive reprogramming of all their payment systems. Other carriers such as Medicare and some of the Blue Shield companies will implement dual-processing systems that will accept both ICD-9 and ICD-10 codes directly and will not rely on crosswalk mapping.

Payers must update all of their systems to accept the new seven digit codes. Some of that work was done through implementing the 5010 standards, which have been required since 2012.

Over the last year, most of the major insurance carriers have published articles in their newsletters concerning the general steps they will be taking to be ready for the ICD-10 conversion. Many offer provider outreach, training programs and opportunities to test claims, as well as ICD-10 tools and resources on their websites. Providers and staff should be taking advantage of these programs.

Of course some payers may not be ready to make the transition on time, which could result in slowed claims processing and payment. Payers may also examine claims more carefully looking for coding discrepancies, particularly for "unspecified" codes.

[5] ICD-10 FAQ, AAPC website
[6] CMS Webinar: Basic Introduction to ICD-10CM

ICD-10 BENEFITS

Training of providers, staff, coders and system upgrades require time and money; all coming at a time when the healthcare industry often feels bombarded with HIPAA, PQRS, EHR Meaningful Use and other government regulations and programs.

However, switching to ICD-10-CM will be beneficial to everyone. ICD-10-CM codes have the potential to reveal more about quality of care, so that data can be used in a more meaningful way to understand complications, better design clinically robust algorithms, and better track the outcomes of care. ICD-10-CM incorporates greater specificity and clinical detail to provide information for clinical decision making and outcomes research.[7]

Adding these detailed ICD-10 codes should streamline claims' submissions since precise diagnosis codes should reduce the amount of rejected claims due to non-specific diagnoses and result in fewer requests for additional clinical information describing the patient's condition.

The expanded degree of specificity should provide more detailed information, which would assist providers, payers, and policy makers in establishing appropriate reimbursement rates.[8]

ICD-10 BACKGROUND

The International Classification of Diseases (ICD) is a diagnosis coding system implemented by the World Health Organization (WHO) to track diseases. ICD-10 (tenth revision) was implemented in 1993 to replace the ICD-9 system developed in the 1970s. The United States is one of the few countries in the world which has not implemented ICD-10, but instead continues to use the ICD-9 coding system.

In August 2008, as part of the HIPAA Administrative Simplification, HHS mandated the implementation of ICD-10-CM (clinical modification) to replace ICD-9-CM for diagnosis coding and the ICD-10-PCS (Procedure Coding System) for inpatient hospital procedure coding with the compliance date originally set for October 1, 2013.

The decision to switch cited many important reasons;[9]

- ICD-9 is 30 years old and has outdated and obsolete terminology, uses outdated codes that produce inaccurate and limited data, and is inconsistent with current medical practice by not accurately describing the diagnoses and inpatient procedures of care delivered in the 21st century. ICD-10 has the ability to expand codes in order to capture additional advancements in clinical medicine.
- There is no more room in the ICD-9 system to add new codes as medical science continues to make new discoveries
- Computer science, combined with new, more detailed codes will allow for better analysis of disease patterns and treatment outcomes that can advance medical care.

[7] Barta, Ann; et al.,"ICD-10-CM Primer." Journal of AHIMA 79, No. 5, May 2008.
[8] BHazelwood, Anita, "ICD-9-CM to ICD-10-CM: Implementation Issues and Challenges,", AHIMA's 75 Anniversary National Convention and Exhibit Proceedings, October 2003.
[9] ICD-10-CM/PCS: An Introduction, www.cms.gov/ICD10

ICD-10 Impact and Benefits

The ICD-10-CM system consists of more than 69,000 codes, compared to approximately 14,000 ICD-9-CM codes. The guidelines, rules and organization of ICD-10 are very similar to ICD-9, but the coding format and description of codes are very different.

- All ICD-10-CM codes are alpha-numeric and include all letters except, "U", providing a greater pool of code numbers.
- ICD-9-CM codes have a maximum of 5 digits, while ICD-10-CM codes have a maximum of seven digits and letters. The first character is alpha, 2nd – 7th is alpha or numeric and the 7th character is used in certain situations (obstetrics, musculoskeletal, injuries, and external causes of injuries).
- Laterality (side of the body affected) has been added to relevant codes
- Injuries are grouped by anatomical site rather than type of injury
- Code titles are more complete; no need for coders to refer back to category, subcategory, or sub-classification level to determine the complete meaning of the code
- The seventh digit will indicate an initial or subsequent encounter or the sequela (abnormal condition resulting from a previous disease)
- Many more codes have been added to describe post-operative or post-procedural conditions
- Expanded use of combination codes which are used for both symptom and diagnosis, and etiology and manifestations
- Excludes Notes: Indicates where 2 conditions cannot occur together and where the condition excluded is not part of the condition represented by the code but the patient may have both conditions at the same time
- Many new codes have been added, such as codes for blood type and alcohol level
- Codes reflect modern medicine and updated medical terminology

Additional ICD-10 Information

More information on the ICD-10-CM conversion can be found from CMS , in this Kim Reid article, in this AHIMA Toolkit and in the HIMSS ICD-10 PlayBook.