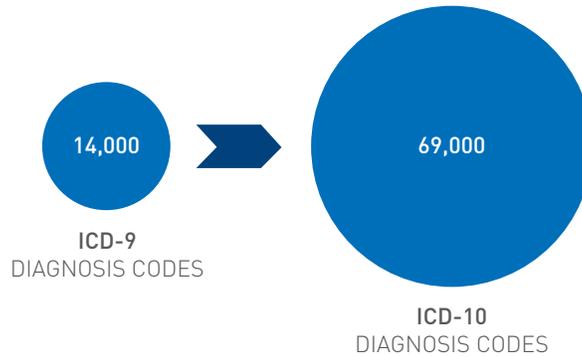


## NUMBER OF CODES



## CODE STRUCTURE

### ICD-9-CM CODE FORMAT



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

### ICD-10-CM CODE FORMAT



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

## ICD-10 HISTORY



# ICD-10 Implementation Plan For Physicians

At this point, it seems quite clear that ICD-10 will be implemented on October 1 of this year. Most physicians and hospitals are ready and busy with final preparations.

Recent surveys<sup>1 2</sup> highlight some of the issues remaining for ICD-10 implementation: primarily provider readiness and testing. In this paper, we outline the steps your practice or department must be taking now to avoid these and other issues.

ICD-10 impacts most aspects of your workflow as well as your key stakeholders. All personnel, systems and functions must be included in your ICD-10 plan. This includes everything from patient scheduling to billing of the visit or procedure.

Practice or department leadership should be focused on three areas of risk:

1. A new approach to documentation
2. Medical necessity; are your referring physicians ready? If you refer, are your orders ready?
3. Budget for disruptions

We describe how to manage your ICD-10 implementation by focusing on these risk areas: financial, training, system/vendor and payer contracts.

**AT A GLANCE:**

Physicians and hospitals must be implementing:

- A new approach to documentation
- Orders that meet medical necessity requirements
- Detailed Contingency Plans

**Table of Contents**

A NEW APPROACH TO PHYSICIAN DOCUMENTATION ..... 02

MEDICAL NECESSITY: ARE REFERRING PHYSICIANS READY? ..... 03

BUDGET FOR DISRUPTIONS ..... 03

Who Will Lead the Process? ..... 03

The Financial Plan ..... 04

Financial Assessment ..... 04

ICD-10 Impact ..... 04

Training ..... 05

Systems and Vendors ..... 05

Contracts and Payors ..... 06

CONCLUSION ..... 06

APPENDIX ..... 07

ICD-10 Benefits ..... 07

<sup>1</sup> Conn, Joseph, "More ICD-10 Anxiety: Third-party Billers say Neither Tech nor Clients are Ready", *Modern Healthcare*, April 10, 2015

<sup>2</sup> [WEDI Workgroup for Electronic Data Interchanges ICD-10 Survey Results](#), Letter to HHS, March 31, 2015

## A NEW APPROACH TO PHYSICIAN DOCUMENTATION

Yes, physicians and other providers must participate in the training process, and very soon, if they aren't already. They need education on the expectations of ICD-10 and how to align documentation with it. ICD-10 challenges the way physicians document the patient episode and demands a greater level of specificity. This may mean capturing new information about the patient's condition (that the physician never documented before) or updating, modifying or expanding the physician's documentation. That said, physicians with good documentation habits will find the transition much easier than those who currently use abbreviations or other shortcuts.

Documentation specifics vary by specialty. Some of the common elements are:

- Laterality: all bilateral sites require codes indicating left or right (e.g. fracture of the left ulna)
- Injuries must specify the stage of treatment: initial encounter, subsequent encounter with routine healing, subsequent encounter with delayed healing, etc.
- There are similar requirements for additional detail in areas such as diabetes, alcohol and substance abuse, and postoperative complications

With diagnosis codes expanding from 14,000 to approximately 68,000 and from 3-5 characters to 3-7 characters, the increase in specificity is clear. At the same time, just like today, no physician uses all of the codes - only a specific subset.

Physician training should begin with a good overview of ICD-10 followed by concentration on their specialty. Physicians should prepare their documentation for ICD-10 by:

- Prioritizing the clinical conditions most commonly encountered (*this step should be complete by now*).
- Identifying new documentation concepts required to support ICD-10 with a focus on the most common conditions seen.
- Auditing current documentation to determine patterns of missing information that may impact coding and reimbursement. Specialists should look carefully at referrals/orders (*this step should be underway or complete by now*). Once the audits are completed, the next step is to concentrate initial improvement efforts on those providers and/or service lines that offer the greatest opportunity or risk in terms of revenue impact.<sup>3</sup>
- Identifying the top 10-15 diagnoses or conditions and comparing current documentation to the requirements of ICD-10 coding. By doing this, physicians can determine their documentation strengths and weaknesses and determine how they will need to change their documentation (*this step should be complete by now*).
- Develop an ongoing documentation quality monitoring and improvement program.
- Create templates within EHR systems or paper-based templates to guide required documentation in common clinical areas (*this step should be complete by now*).
- Physicians who dictate reports need to ask their coders if the reports have the level of detail necessary to assign specific ICD-10 codes. A practice should use experienced auditors or coders to review physician documentation, whether the auditor is internal or is hired from the outside (*this step should be underway or complete*).

<sup>3</sup> Piselli, RN, MBA, FACHE, Caroline, "Clinicians and ICD-10; Meeting Complex Documentation Requirements," Clinical Informatics Insights, February 2011.

## MEDICAL NECESSITY: ARE REFERRING PHYSICIANS READY?

If you a specialist, you are very dependent on the information provided by the primary care or referring physician. If you are a referring physician, the specialists to whom you refer are very dependent on the specifics in your order.

This is because the order must now have sufficient specificity to match the more detailed ICD- 10 codes. A specialist will probably not get paid if the diagnosis is too general or mis-matched with the performed procedure done. On the other hand, more complete diagnosis information should improve the ability of the specialist to perform the right test or begin their assessment at a better starting point.

Specialists can help referring physicians understand the more detailed ICD-10 coding system and the associated new documentation requirements when ordering tests or sending patients to the specialist. Specialists should already have contacted their most important referring physicians to work with them to help them understand how ICD-10 impacts medical orders. As an example, in ICD-9, the referring physician may be using Anal and Rectal Polyp (ICD9 code 569.0). Under ICD-10, this description becomes two separate codes and the physician will need to distinguish between Anal Polyps (K62.0) and Rectal Polyps (K62.1).

Specialists need to determine if their ordering physicians need to give more or different information or if the specialist must adapt the content of their report to support the new coding system.

Specialists should ask themselves:

- Do I receive the necessary clinical history on a patient prior to performing the study or seeing the patient?
- Do I see the referring physicians' orders? Does it contain specific signs and symptoms?

As an example, the College of American Pathologists (CAP) says the ICD-10 implementation can help pathologists gain better access to EHR patient records and position themselves as leaders in coordinated care.<sup>4</sup> This would hold true for other specialists as well.

## BUDGET FOR DISRUPTIONS

### Who Is Leading the Process?

By now, someone (or a committee) must be leading your ICD-10 implementation. Leader(s) should be knowledgeable about all functions and understand the importance of accurate clinical documentation. This can be the job of two people;

- A project leader to ensure current processes run smoothly while ICD-10 implementation stays on track, and
- A "content" expert (maybe a nurse, physician, or lead coder) very familiar with ICD-9 so he or she can be involved in and/or lead training, etc.

A small practice or department without these skills should have already hired someone from the outside to help facilitate the transition.

<sup>4</sup> "Turn the Challenging ICD10 Switch Into a Leadership Opportunity," [http://www.cap.org/apps/docs/membership/transformation/new/pm\\_icd10\\_article.pdf](http://www.cap.org/apps/docs/membership/transformation/new/pm_icd10_article.pdf)

The lead person/team should have already done the Impact Assessments that follow; if not, they need to be started immediately.

## The Financial Plan

One critical dimension, and one that leadership must oversee, is the financial plan. The team should already have completed the Financial Assessment (see below) including a risk analysis. Based on this, leadership must decide the amount and form of contingency reserves. One common approach is to establish or expand a bank line of credit (LOC). For example, leadership may decide to have a reserve that represents 3 months of cash flow. A line of credit of that size must be established in advance of the need for it. This is because it is much easier to get the LOC when the organization can demonstrate a steady cash flow than when the cash is delayed. At the same time, many lines of credit have a fixed term, often 12 months. Therefore, the optimum time to establish, renew or expand the LOC is late summer, which means starting bank discussions now.

## Financial Assessment

Practices and departments must already have an approved ICD-10 budget including:

- Software modifications (in-house and vendor system changes), and hardware procurement or upgrades (these should already be in place),
- Education for physicians, coding staff and other personnel needing education,
- Testing-related costs,
- Staff time and temporary or contract staffing to assist with increased work resulting from the transition as well as staff training.

Contingency planning should include a back-up plan and budget for possible cash flow interruptions caused by coding and billing slow-down/back-logs, coding accuracy reviews and third parties (especially payers) who aren't ready.

While the industry is working to minimize disruptions, there is a risk of cash flow interruption that organizations ignore at their peril. Kerry Stark, senior director of Revenue Cycle Management Services at VHA, Inc., suggests the following questions be asked to prepare for a possible negative impact to reimbursement and cash flow:

- What managed care contracts need to be updated? (It is recommended that contracts have language added saying that ICD-10 will not impact contracted payment amounts).
- How will the organization monitor contract compliance and track reimbursement accuracy?
- What will be the impact to financial reserves and working capital?
- How will dual payment processing under ICD-9 and ICD-10 impact financial reporting?
- What financial resources, in terms of capital and operational dollars, are required to implement ICD-10?

## ICD-10 Impact

In addition to the Financial Assessment, your ICD-10 team should have the following assessments in place:

**Who is involved in (i.e. touches) medical documentation, coding and billing?**

**Who uses ICD-9 coding now and therefore needs training for ICD-10?**

Most staff in your organization are probably involved with diagnoses in some capacity – your appointment scheduler (who should document the patient's reason for coming to see you), front desk staff, nurses, the person who pre-authorizes studies for specialists, coding specialists and billers.

**What systems in your practice use medical documentation or ICD-9 coding?**

The switch to ICD-10 affects practice management systems, the electronic health record and computer system components or modules that currently use ICD-9 codes as part of their logic, such as patient problem lists, appointment scheduling, prevention intervention alerts, system interfaces, A/R and other financial reports. For specialists this also means RIS, LIS, and PACS systems.

**What other major office projects are currently in process in the same timeframe?**

Many organizations have current projects on PQRS and/or other quality measurement programs, EHR and meaningful use, ACO involvement, etc. While ICD-10 will assist, and be required for, many of these projects, realistic budgets are needed for each project, including ICD-10.

**Everyone must buy-in to the ICD-10 transition.**

The ICD-10 leader or team now needs to re-emphasize the expectation that the practice or department must and will be ready for ICD-10 by October 1 and to not take ICD-10 implementation lightly: your organization’s income relies on a smooth transition. In some cases, this will be a challenge since the multiple delays have encouraged skeptics to “wait and see.”

**Training**

It is essential that staff as well physicians be educated on all aspects of ICD-10. By now, your ICD-10 team should have the training in place and scheduled (if not underway) for each employee in your office.

Actual ICD-10 code training should have started by now. Training can include:

- Sending selected employees to medical coding classes or boot camps.
- Face-to-face classroom teaching
- Audio conferences and webinars
- Self-directed learning programs
- Self-directed or instructor-led web-based instructions

If you have coders on staff, they should be well along, or completed with, their anatomic training, know the ICD-10 coding for your most common ICD-9 diagnoses and have a timeline to achieve ICD-10 certification.

**Systems and Vendors**

Practice management, EMR, billing systems and systems that feed into billing systems must be upgraded to ensure all forms are 5010 compatible and can store and transmit both ICD-10 and ICD-9 codes. Most or all of these upgrades should be in place by now. A checklist of each system, its upgrade status and testing status is essential.

A time-line must be in place and underway for testing all systems. It is of utmost importance that all systems are tested well before October 1. There are always issues to iron out and vendors and insurance carriers are highly likely to be back-logged by September, if not sooner.

Both ICD-9 and ICD-10 code versions must be maintained for some time so that claims can be submitted for services before and after the ICD-10 implementation date. Organizations that participate in clinical trials or other research studies where diseases must be tracked consistently over long periods of time will need to have both coding systems available.<sup>6</sup>

<sup>5</sup> McNickle, Michelle, “[5 Tips for ICD-10 Implementation](#),” February 15, 2012, Healthcare IT News

<sup>6</sup> Kuehn, MS, RHIA, CCS-P, FAHIMA, Lynn, “[Preparing for ICD-10-CM in Physician Practices](#),” AHIMA

If your office does its own coding, technology to help with proper code assignment should be in place by now; e.g. Coding Clinic, drug references, medical dictionaries, or office coding guidelines.

### Contracts and Payors

Including ICD-10 in insurance contract negotiations ensures that services you bill for with ICD-9 codes will still be covered when the new diagnoses codes are in effect, and at the same rate. In the future, insurance carriers will be changing their medical policy coverage to be in line with more specific ICD-10 codes, which will result in greater payment for greater diagnosis complexity and lower payment for lower complexity. With the increased usage of EMRs, payors will be less inclined to accept "unspecified" or "other" codes, so if you continue to submit these codes, carriers may deny claims stating that with so much clinical information available via the EMR, there is no reason to not provide a specific diagnosis. Fortunately, most carriers will probably accept "unspecified" or "other" codes in 2015 and early next year. Specifically, Medicare has announced "they will not deny claims solely on the specificity of the ICD-10 code as long as the physician used a validation code from the right family. However, a valid ICD-10 code will be required on all claims starting on October 1, 2015".<sup>7</sup>

A large concern at this point is those carriers who will not be ready October 1; your staff needs to be able to prepare billing accordingly to ensure proper and prompt payment. We saw this happen with 5010, where some carriers were not ready on January 1, 2012 to accept 5010 submissions and billing had to be submitted via 4010 until their systems could accept 5010. Of course, if you use a billing service, this is one of the areas they will handle on your behalf.

## CONCLUSION

ICD-10 is going to happen and moving to the new codes affects every aspect of how your practice or department operates. You must be ready. With any change of this magnitude, there will be bumps, some large and some small, but you have the power to minimize them by being prepared. And, you will benefit current operations in the meantime.

This white paper has described what is needed in your ICD-10 implementation: including of ICD-10 impact on financials, training, systems, vendors, contracts and more. Most importantly, we've described how leadership can minimize the three largest areas of risk:

1. A new approach to documentation
2. Medical necessity: are your referring physicians ready? If you refer, are your orders be ready?
3. Budget for disruptions.

Please contact your AdvantEdge Client Manager or Sales person for more information.

<sup>7</sup> CMS and AMA Announce Efforts to Help Providers Get Ready for ICD-10

## APPENDIX

Our companion whitepaper “ICD-10 Impact and Benefits” provides a comprehensive description of ICD-10, the background and the benefits. It also describes the impacts on:

- Physician documentation
- Physician orders
- Physician practice financials
- Coding
- Billers and billing companies, and
- Payers (insurance companies)

### ICD-10 Benefits

ICD-10 can assist practices in providing higher quality data, improved efficiencies and lower costs.<sup>8</sup> Usage of ICD-10 aligns with the requirements for ACOs, quality measures, EHR implementation and value-based reimbursements.

Higher quality data from ICD-10 will result in:

- Improved ability to measure the quality, efficacy, and safety of patient care
- Increased sensitivity when refining grouping and reimbursement methodologies
- Enhanced ability to conduct public health surveillance
- Greater achievement of the anticipated benefits from electronic health record adoption
- Improved efficiencies and lower administrative costs by increased use of automated tools to facilitate the coding process
- Decreased claims submission and claims adjudication costs by coding more specificity in clinical documentation
- Potential financial benefits by billing for more complex treatments associated with high-risk patients and more accurate payment for new procedures
- Fewer miscoded and rejected claims
- Decreased need for manual review of health records to meet the information needs of payers, researchers, and other data mining purposes
- Improved resource management
- Reduced labor costs
- Increased productivity

<sup>8</sup> 1 Bowman, Sue, and Ann Zeisset, “ICD-10 Preparation Checklist,” September 2012, [http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1\\_048737.pdf](http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_048737.pdf)