NUMBER OF CODES

14,000

ICD-9 DIAGNOSIS CODES

69,000

ICD-10 DIAGNOSIS CODES

CODE STRUCTURE

ICD-9-CM CODE FORMAT

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

CATEGORY ETIOLOGY, ANATOMIC SITE, MANIFESTATION EXTENSION

3 TO 5 CHARACTERS
FIRST DIGIT IS ALPHA
ALL DIGITS EXCEPT SECOND ALPHA OR NUMERIC

ICD-10 HISTORY

1979 ICD-9-CM ADOPTED FOR HOSPITAL USE

1988 WORLD HEALTH ORGANIZATION ADOPTS ICD-10

1994 HIPAA LEGISLATION INTERRUPTS ICD-10 ADOPTION

1996 CMS PROPOSED RULE TO ADOPT ICD-10 OCT 2011

2008 CMS PROPOSED RULE TO ADOPT ICD-10 OCT 2013

2009 CMS DELAYS IMPLEMENTATION ONE YEAR

2013 CONGRESS DELAYS IMPLEMENTATION ONE YEAR

2014 IMPLEMENTATION OCTOBER 1

2015

Getting Ready for ICD-10

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Getting Ready for ICD-10

ICD-10 is scheduled for October 1 of this year even though some observers think another delay is possible. But physicians and hospitals need to be preparing since the odds favor implementation this year.

WILL ICD-10 BE DELAYED AGAIN?

We believe the political process is likely to yield a clear direction on ICD-10 by early April, if not sooner. Congress has begun to hold hearings to assess CMS and industry readiness. Most industry participants and many physicians are prepared and strongly support moving to ICD-10, without further delay. In contrast, the AMA remains opposed. But only one expert testifying in the February hearing was opposed, while six strongly supported 2015 implementation.

The Medical Society of the State of New York, the Texas Medical Association and the National Physicians’ Council for Healthcare Policy lobbied Congress to include an ICD-10 postponement to 2017 in the “Cromnibus” bill that passed Congress in mid-December to fund the federal government for the balance of the fiscal year. But that effort was unsuccessful.

As a result, House Rules Committee Chair Pete Sessions (R-Texas) and House Energy and Commerce Committee Chair Fred Upton (R-Mich.) issued a joint statement:

"The Energy and Commerce Committee has been working with CMS to ensure the October 1, 2015, implementation is achieved and is prepared to have a hearing on the issue in the New Year.

'As we look ahead to the implementation date of ICD-10 on October 1, 2015, we will continue our close communication with the Centers for Medicare and Medicaid Services to ensure that the deadline can successfully be met by stakeholders,’ said Upton and Sessions. ‘This is an important milestone in the future of health care technologies, and it is essential that we understand the state of preparedness at CMS. Following the most recent delay of ICD-10, we heard from a number of interested parties concerned about falling behind or halting progress. We would like to acknowledge and thank these organizations and individuals for opening up this dialogue and expressing their thoughts and concerns regarding this issue. It is our priority to ensure that we continue to move forward in health care technology and do so in a way that addresses the concerns of all those affected and ensure that the system works.’"

The bottom line is that these hearings are listening to both sides in the debate about delaying ICD-10. Congress has to deal with the SGR issue before the end of March when the current “SGR fix” expires. Those lobbying for a delay will be doing everything possible to include it in the SGR legislation while opponents of delay will be lobbying equally hard to prevent further delay.

Those who wait on the Congressional “decision” before getting serious about ICD-10 preparation will have a host of last minute preparations. It should be pointed out that the delay in 2014 resulted from “back room” negotiations with virtually no one taking public “credit” for the delay. With the public hearings new underway, that is highly unlikely to happen in 2015.

AT A GLANCE:

ICD-10 less likely to be delayed
Preparation is essential now
Train staff & physicians
Verify systems
Review payor contracts
Have financial contingency
Test, test, test...
GETTING READY FOR ICD-10

PREPARATION FOR ICD-10

Without a crystal ball to see if ICD-10 gets postponed yet again, hospitals and physicians have no choice but to be prepared. The rest of this article emphasizes the steps that hospitals and physician groups need to take during 2015 to be fully prepared. These include:

- Train staff
- Train physicians
- Verify that all systems are updated
- Review payer contracts and procedures
- Financial contingency planning
- Test, test, test

TRAIN STAFF

By now, hospitals and physician groups should have a specific plan for the required training for each employee with a timeline for training. If not, creating the plan must be an urgent priority.

Actual ICD-10 code training should start in the first and second quarters, using the final ICD-10 code version. 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, and
- Self-directed or instructor-led web-based instruction.

If you have coders on staff, their training should have already started so that, ideally, they can be certified in ICD-10 before October. In any case, a list of the most common ICD-9 diagnoses and how they are coded in ICD-10 is a must for both coders and physicians.

If coding is done by an outside party, it is important to review their training plan and assure that you are confident in their ability to be ready.

TRAIN PHYSICIANS

Yes, physicians must participate in the training process. They need education on the expectations of ICD-10 and how to align documentation with coding guidelines. ICD-10 challenges the way many physicians document the patient episode or test, demanding a greater level of specificity. This may mean capturing information about the patient’s condition that the physician never documented before. Physician training should begin with a good overview of ICD-10 followed by concentration on their specialty. Physicians should:

- Identify the top 10-20 diagnoses or conditions currently seen and compare current documentation to the ICD-10 requirements. By doing this, physicians can see their documentation strengths and weaknesses and determine how they need to change their documentation.
- Audit current documentation to determine patterns of missing information that will impact coding and reimbursement. Specialists should look carefully at referrals (orders).
- Create templates within EHR systems or paper-based templates to guide required documentation in common clinical areas.

Physicians who have coding done from dictated reports need to ask their coders if the dictated reports provide the level of detail necessary for ICD-10 codes. If documentation is not specific, coders will not be able to code to the
ICD-10 level of specificity and will ask for additional information, slowing the entire billing process.

A practice not using outside coders should ask experienced auditors or coders to review physician documentation.

VERIFY THAT SYSTEMS ARE UPDATED

Practice management, EMR, billing and systems that feed into billing systems must be upgraded to ensure they can store and transmit both ICD-10 and ICD-9 codes. At this point, your hospital and practice should have a firm upgrade schedule for each system: to be complete no later than the end of the summer and preferably sooner.

Maintaining both ICD-9 and ICD-10 code versions for some time is critical so that claims may be submitted for services before and after October 1 and for the ability to resubmit unpaid claims with service dates prior to October. Practices and hospitals that participate in clinical trials or research studies where diseases must be tracked consistently over long periods of time will need to have both coding systems available.

The system time-line must emphasize testing all systems. It is of utmost importance that all systems are tested well before the go-live date. Don’t be testing at the last minute, as there are always issues to iron out and vendors and insurance carriers are highly likely to be back-loged in the third quarter, especially September.

Make sure ICD-10 transition terms and schedules are in your vendor contracts. This includes being clear about incremental costs, including testing.

REVIEW PAYER CONTRACTS AND PROCEDURES

ICD-10 must be in your insurance contract negotiations to ensure that services you bill for with ICD-9 codes will still be covered when the new diagnosis 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 by stating that with so much clinical information available via the EMR, there is no reason to not provide a specific diagnosis.

It is also critical to stay in close touch with your major payers to know which carriers will not be ready by the deadline. 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. If you use a billing service, this is one of the areas they will handle on your behalf.

FINANCIAL CONTINGENCY PLANNING

Hospitals and physician practices must have a budget in place for implementing ICD-10 including:

- Software modifications (in-house and vendor system changes), and hardware procurement or upgrades,
- Education for physicians, coding staff and other personnel,
- Testing, and
- Staff time and temporary or contract staffing to assist with increased work during the transition and during 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. Leadership must decide the amount and form of contingency reserves. One common approach is to establish or expand a bank line of credit (LOC). Many experts are recommending a reserve that represents 2 to 3 months of cash flow. A line of credit of that size must be established in advance of the need for it because it is much easier to get the LOC when the hospital or practice can demonstrate a steady cash flow than when cash is delayed. But, 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.

TEST, TEST, TEST

A key part of an effective ICD-10 plan is assuring that the organization is ready prior to October 1. The most obvious area for testing is with systems, especially those that affect payment. Unfortunately, testing with insurance companies is dependent upon their testing schedules. But whether your billing is done in house or by a billing service, make sure the test schedule is established and monitored.

Testing of staff and physicians is, in some ways, more challenging since it can’t be done too soon but it must be done far enough in advance to correct any issues that are identified. One recommended best practice is to perform “dual coding” for a select period of time or selected cases. This means creating the ICD-9 codes needed for current operations and ICD-10 at the same time. While this approach is not feasible for all cases, it will identify many issues that can be fixed before October. An ideal timeframe for dual coding is mid-summer.

SUMMARY

Whether we personally “like” ICD-10 or not, it is a pre-requisite for many advancements in healthcare. But these longer term benefits come with short-term costs that need to be addressed now. This article has outlined the major steps that hospitals and physicians need to take in 2015 to successfully implement ICD-10 on October 1. While some issues are sure to arise, organizations who take these steps will find the transition much easier than those who do not prepare adequately.