

A McKesson Perspective for Physicians: ICD-10-CM/PCS

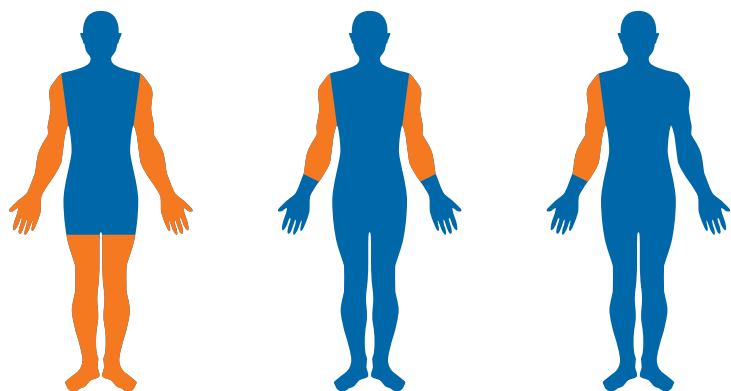
The Gathering Storm: Coding Changes Will Have a Far-reaching Effect on Your Practice

Given the complexity of issues facing the healthcare industry, it is no surprise that yet another equally momentous matter has not received everyone's full attention: ICD-10, a new set of diagnosis codes that all U.S. physician practices must use starting on Oct. 1, 2013. Failure to prepare for this looming transition could have serious financial consequences for physicians, hospitals and other organizations.

Beginning Oct. 1, 2013, the U.S. government is mandating the shift from the existing ICD-9 code system to ICD-10-CM (diagnoses) and ICD-10-PCS (procedures) — a coding standard already in use in many other developed countries around the world. The change will expand the number of codes by almost eight-fold, from about 20,000 to more than 155,000. The differential between the number of ICD-9 and ICD-10 codes will mean that, in many instances, no "crosswalks" will exist for a one-to-one code match.

The ICD-10 code set expands the field length of the code. The expansion enables the addition of codes to support advances in medicine and to provide greater specificity in clinical documentation. The codes differentiate body parts, surgical approaches and devices used. Injuries are grouped by body part rather than category of injury. Mastering ICD-10 will require that all coders possess in-depth knowledge of anatomy, physiology, medical terms, disease processes, surgical procedures and pharmacology. *(See the Appendix for more information on the expanded code set and its origins.)*

The good news is that while the ICD-10 transition will be disruptive in the short term, it should have a positive outcome over the longer term. The expansion will benefit the delivery of care by indicating a more precise



ICD-9
729.5 Pain in Limb

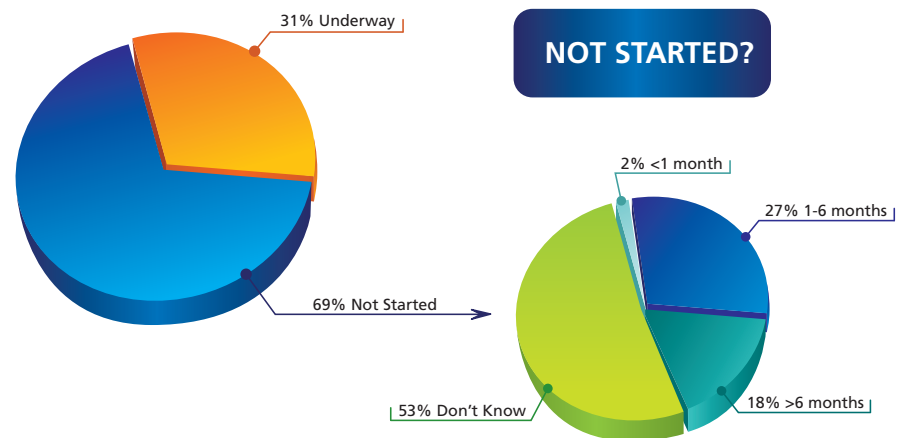
ICD-10: Specific Site
M79.62 Pain in
Upper Arm

ICD-10 Laterality
M79.622 Pain in
Left Upper Arm

ICD-10 provides greater specificity in clinical documentation.

diagnosis, and more accurately matching the payment for care to the care delivered. In time, this improved precision will promote greater efficiencies in care documentation and claims processing. The greater detail also will provide organizations with improved business intelligence regarding care delivery and operations.

Because the code set transition will affect not only claims and collections, but virtually all aspects of a provider's business, it is important that organizations begin preparing for the transition today. The ICD-10 transition plan at your practice will require staff education, possible staff augmentation, updating of IT systems, assessment of clinician workflow processes, and analysis of cash flow and budget impact.



Only 31% of healthcare providers/facilities have started ICD-10 planning and implementation.¹

Project Planning

- **Get Buy-in and Budget from Leadership:** Educate senior leaders on the impact and importance of ICD-10 readiness. Maintain ongoing communications about the project and its status. Get buy-in for expenses related to the transition, such as training and system upgrades.
- **Create a Multidisciplinary Task Force:** Establish an internal task force that represents the functional areas that will be affected by the code set change, such as information systems, business office, physicians, other clinicians, executive leadership and finance.

¹ Source: American Health Information Management Association, 5010 and ICD-10 Planning and Implementation Survey Results, July 2010

Identify policies, procedures and authority for ensuring compliance with appropriate coding and the detailed clinical documentation required to submit ICD-10 claims.

- **Create a Governance Structure:** Identify policies, procedures and authority for ensuring compliance with appropriate coding and the detailed clinical documentation required to submit ICD-10 claims. A well-defined governance structure will prevent coder workflow disruption due to lack of compliance by clinicians in providing necessary documentation details.
- **Establish a Project Plan and Timeline:** In your planning, address activities required to meet the 2013 deadline, such as a readiness assessment, coder training, physician training and information system upgrades.
- **Create a Communications Plan:** Educate the entire organization about how the change will affect policies and procedures. Stress the importance of the project since it affects reimbursement and accounts receivables.
 - Provide ongoing status updates to maintain focus on the project and upcoming initiatives that require staff involvement.
 - Provide regular updates to senior leaders and those most directly affected by the changes, such as coders, clinicians and physicians.

Education for Coders and Physicians

- **Physicians:** Physicians will need training on the documentation detail required to support ICD-10 coding related to their specialty or practice. Due to the precise nature of the codes, physicians will need to provide comprehensive documentation so that coders can select the correct code. Proper documentation will help ensure accurate and speedy reimbursement. As part of the process, some documentation templates will likely need to be revised.
- **Coders:** Coders will need training on the expanded code set. Some industry organizations are estimating that learning the ICD-10 code set may take up to two weeks for most professional coders. An American Health Information Management Association (AHIMA) "ICD-10-CM Field Testing Project" in 2003 estimated approximately 50 hours of training for experienced, professional coders. In addition, the new code set will require significantly increased coder knowledge of medical procedures and anatomy due to the clinical specificity of the new code sets. Anatomy refresher courses for all coders are highly recommended.

Ensure that training is completed in time to develop proficiency but without being so far in advance that knowledge is lost. Having a dual coding environment available will enable staff to practice in the new code set.

Resource Management and Assessment

- **Assess Coding Staff Levels.** In addition to the loss of productivity during the training and testing phase, CMS and AHIMA have estimated an anticipated decrease in coder productivity for three to six months after implementation of the new code set.

- **Assess Staff Knowledge:** Evaluate whether you need additional experienced coding staff. Analyze your staff's knowledge of medical procedures and anatomy, which are important to selecting the right ICD-10 code. Coders may need training in these areas.
- **Evaluate Outsourcing:** As you assess the transition's impact to your organization, you may want to consider outsourcing your current coding during the preparatory stage. Outsourcing will allow for just-in-time training and reduce the burden of the transition on staff.
- **Don't Wait to Hire Experienced Coders:** Hospitals, payers, independent practices and associated hospital specialty groups all will be reviewing current staffing levels and considering staff augmentation or outsourcing. There will be competition for qualified, certified coders with the anatomical knowledge needed to select the correct code in the new code set. If you are considering temporary or permanent staff increases, finalize your plans soon.

Early Cut-Over and Support for Dual Coding Requirements

- **Select Your Cut-over Date:** The formal compliance date is Oct. 1, 2013, but you may want to transition sooner.
 - Before your cut-over date, you must consider several factors:
 - **Experience in a Production Environment:** Allow your staff ample time to work with the new code set in a production environment prior to the Oct. 1, 2013 transition date. This time will provide your staff with practical experience and enable planners to identify and address problem areas before they affect cash flow.
 - **Discharge Date-determined Code Set:** The requirement for the 2013 code cut-over is for any patient admitted prior to the date, but discharged on or after Oct. 1, 2013.
 - Patients admitted and discharged before the date are coded using ICD-9.
 - Patients discharged after the date (regardless of admit date) are coded with ICD-10.
 - Re-bills must use the same code set as the original bill.
 - **Non-HIPAA-covered Organizations:** Non-HIPAA-covered organizations (such as workers compensation and automobile insurance companies) are not required to move to ICD-10. While they may ultimately shift to the new code set, your organization should anticipate creating and processing ICD-9 transactions for these organizations at the same time as ICD-10 for HIPAA-covered organizations.
- **Early Cut-over Means Dual Coding:** Make sure your systems support dual coding (ICD-9 and ICD-10) environments, and your test plans account for

this requirement. Even though you may be ready, you cannot submit the ICD-10 codes prior to October 2013.

Aggressive Management of the Revenue Cycle

- **Analyze Rejected and Unbilled Claims:** Current coding challenges will multiply with the introduction of ICD-10. By starting now, you can use your transition time to mitigate existing problems while minimizing the introduction of new ones. Focus on optimizing each phase of the revenue cycle — especially denied and not-final-billed claims. Evaluate the reasons behind reimbursement delays. Analysis of denials and delays may uncover the need for additional staff or training. Work with individual coders on productivity and with physicians on meeting documentation requirements.
- **Assess Service Line:** Review the ICD-9 and equivalent ICD-10 coding that supports your key service lines and most commonly assigned and highly reimbursed DRGs. Ensure that you have training plans for these essential codes and have addressed clinical documentation requirements. The government is providing General Equivalency Mappings (GEMs) to help in the development of code mapping tools. When there are multiple ICD-10 codes that replace the ICD-9 code, some of the industry-developed mapping tools can provide guidance by displaying the possible or most appropriate ICD-10 code options.
- **Project the Impact to Cash Flow:** Develop a cash management strategy to ensure you have enough cash on hand to cover the transition period. During the transition, plan for a higher percentage of rejected claims due to inadequate documentation or inappropriate coding. Some payers are considering using a translation process that will reverse code ICD-10 submissions to ICD-9 codes for the calculation of the MS-DRG. This reverse mapping can affect reimbursement. Understanding your payer's approach will help you plan accordingly.

Use the transition time to optimize each phase of the revenue cycle while mitigating existing problems.

Information System Management

- **Identify All Systems Affected by ICD-10:** Determine all systems, such as an EHR, natural language processing, practice management system, RIS or similar applications/platforms, affected by ICD-10. Develop a roadmap based on the applications' planned release dates and schedule your slot for implementation, allowing ample time for testing.
- **Schedule Transaction Testing:** Schedule clearinghouse testing of ICD-10-related transactions with your payers. (The testing period began Jan. 1, 2011.)
- **ICD-10 Readiness of Foundational Systems:** Your health information management and billing systems are foundational to your revenue cycle and the ICD-10 transition. Make sure these foundational systems are

Main Areas with Cost Impact	Typical Small Practice	Typical Medium Practice	Typical Large Practice
Education	\$2,405	\$4,745	\$46,280
Process Analysis	\$6,900	\$12,000	\$48,000
Changes to Superbills	\$2,985	\$9,950	\$99,500
IT Costs	\$7,500	\$15,000	\$100,000
Increased Documentation Costs	\$44,000	\$178,500	\$1,785,000
Cash Flow Disruption	\$19,500	\$65,000	\$650,000
TOTAL	\$83,290	\$285,195	\$2,728,780

ICD-10 transition costs vary by practice size²

updated and fully tested, including all necessary inbound and outbound interfaces.

- **Dual Code Support:** Ensure your systems can support simultaneous coding of both code sets since not all commercial payers (such as workers compensation and automobile insurance companies) are not required to move to ICD-10.
- **Schedule Release Upgrades:** Schedule your release upgrades as soon as possible. Every affected vendor has to upgrade its existing applications. Map your upgrade process and proactively budget and schedule upgrade slots with your vendors.

Conclusion

For provider organizations, the transition to ICD-10 will be complex and resource-intensive. Yet the benefits, including more accurate claims and improved business intelligence, should quickly become evident once the new system is in place. For organizations that fail to plan effectively or delay the process, the financial consequences could be severe. That's why healthcare organizations should begin today and proceed methodically but with determined urgency to meet the ICD-10 transition timelines and goals.

²Source: The Impact of Implementing ICD-10 on Physician Practices and Clinical Laboratories. Nachimson Advisors, LLC. Oct. 8, 2008 www.nachimsonadvisors.com

Appendix

The Expanded Code Set: ICD-10

Under the Health Insurance Portability and Accountability Act (HIPAA), the Secretary of the Department of Health & Human Services (HHS) is required to adopt transaction standards and data elements for the electronic exchange of health information for certain healthcare transactions. The secretary is also required to review the HIPAA standards and adopt modifications as appropriate, but not more frequently than once every 12 months. This requirement includes ensuring the routine maintenance, testing, enhancement and expansion of code sets.

The International Classification of Diseases, 9th edition, Clinical Modification (ICD-9-CM) is the clinical code set currently used to report diagnoses and procedures in healthcare encounters. The ICD-9 code set is based on the World Health Organization's (WHO) International Classification of Diseases.

- ICD-9-CM Volumes 1 and 2 are created and maintained by the National Center for Health Statistics to report diagnosis codes.
- Volume 3 of ICD-9-CM, which contains the procedure codes, is developed and maintained by the Centers for Medicare & Medicaid Services (CMS) Coordination and Maintenance Committee.

On Aug. 22, 2008, HHS proposed the replacement of the ICD-9-CM code set with ICD-10-CM and ICD-10-PCS. After a comment period, HHS issued a final rule for concurrent implementation of the International Classification of Diseases 10th revision on Jan. 16, 2009:

- Clinical Modification (ICD-10-CM) for diagnosis coding.
- Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding.

The new code sets replace the current ICD-9-CM Volumes 1, 2 and 3. The effective date of this regulation was March 17, 2009, with a compliance date of Oct. 1, 2013.

The Constraints of ICD-9

Over time, the use of ICD-9 coded data has expanded beyond its originally intended scope. Today, the codes are used by different types of data collection and reporting systems to support the needs of a variety of stakeholders. However, the code set lacks the specificity to fully describe a disease state or procedure.

Because the ICD-9 system has limited space for adding new codes due to its structure, multiple codes are often required to accurately describe certain procedures. And due to the space limitations, codes have been assigned to inappropriate chapters, adding confusion to the coding process.

The Benefits of the ICD-10 Expanded Code Set

The ICD-10 code set expands the field length of the code. The expansion enables the addition of codes to support advances in medicine and provide greater specificity in clinical documentation. The codes differentiate body parts, surgical approaches and devices used. Injuries are grouped by body part rather than category of injury.

- ICD-10-CM contains approximately 68,000 diagnosis codes. The expanded codes provide the ability to capture specifics such as trimester in pregnancy, external causes of injury, ambulatory care conditions and post-procedural disorders.
- ICD-10-PCS contains approximately 87,000 procedure codes. The first character shows the type of procedure by clinical specialty, and each subsequent character has a specific function that may change depending on the service.

In the final rule, HHS notes that the benefits of ICD-10-CM and PCS will become apparent the year after the code set has been implemented.

Benefits include the following:

- New and more complex procedures will be assigned codes that accurately describe the procedure. The specificity will lead to more accurate payment, in contrast to the current system where new procedures are often inappropriately grouped.
- The specificity and detail in ICD-10-PCS will reduce the need for claim attachments. It is expected to decrease the number of claims that are rejected due to lack of information needed for adjudication.
- The specificity of ICD-10 is expected to reduce the number of miscoded claims that result from the ambiguity of the ICD-9 codes.
- The code set will enable more comprehensive quality reporting and improve disease management through the sharing of disease and morbidity data. In addition, the increased clinical detail will provide more precise disease/condition definitions that can be analyzed for planning, monitoring and improvement efforts.
- More precise business intelligence will be available to measure and improve resource utilization, patient safety, clinical research, contract modeling and management, disease management, and operational and strategic planning.
- Shared global code sets provide expanded opportunities for international benchmarking and best practices. The shared code sets also will improve the ability to track international health threats and enable clinical data comparability with other countries.
- It is anticipated that the transition to ICD-10 will provide the detailed data to support later-stage ARRA meaningful use objectives, quality measures and emerging care delivery models.

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