California Area ICD-10 Update

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Program Directors Meeting

ICD-10 Key Date

- ICD-10 Compliance date is **October 1, 2014**
  - On October 1, 2014, the health care industry will be required to use the ICD-10 code set to code all diagnosis and hospital inpatient procedures in administrative transactions and for various other uses.
  - All services and discharges on or after October 1, 2014 must be coded using ICD-10 code set. Transactions that continue to use the ICD-9 codes will be rejected.

Comparison: ICD-9-CM and ICD-10-CM

Characteristic	ICD-9-CM	ICD-10-CM
Character Type	Numeric, only V & E used	Alphanumeric
Code length	5 digit max	3-7 character max
# of Codes	13,500	**68,000 +**
Supplementary codes	V & E Codes	None (incorporated in main code book)
Laterality (left v. right)	No	Yes
Trimester	No	Yes (1st,2nd,3rd)
Structure of injuries	Wound Type Laceration, etc	Body part

What is SNOMED-CT?

- Systematized Nomenclature of Medicine – Clinical Terms
- Most comprehensive, multilingual clinical healthcare terminology in the world.
- SNOMED-CT is owned, maintained and distributed by the International Health Terminology Standards Development Organization (IHTSDO).

SNOMED-CT and ICD-10 in RPMS

- Providers will select SNOMED-CT terms for Problem List, Purpose of Visit, Family History (and more)
  - Providers will select ICD-10 only if no appropriate SNOMED-CT term is found
- SNOMED-CT will be translated to ICD-10 by mapping tools (and/or coders) for billing and export to the data warehouse
- Clinical documentation will still need to be detailed enough to facilitate ICD-10 coding
- Some training on SNOMED-CT will be required, but SNOMED codes are generally intuitive for providers – natural language

Clinical Documentation Improvement

- **Clinical Documentation Improvement (CDI) is not new –**
  - ICD-10 does not drive Clinical Documentation Improvement
  - ICD-10 benefits depend on Clinical Documentation Improvement
  - ICD-10 (MU, M/M Audits, etc.) can be used as a tool to promote improved documentation and as a tool to facilitate improvement projects
- CDI is about documentation that meets the standards of care

Five Key Steps to Improving Clinical Documentation

- Assess documentation for ICD-10 readiness
- Analyze the impact on claims
- Implement early clinician education
- Establish a concurrent documentation review program
- Streamline clinical documentation workflow

Source: Caroline Piselli, RN, MBA, FACHE, is global program manager of ICD-10 and pay for performance at 3M Health Information Systems

ICD-10 E-Learning

Training Dates

- ICD-10 Implementation & Code Set Training
  - September 17-19, 2013 (In Session)
  - October 22-24, 2013
  - Register at: caoicd10training2.eventbrite.com
- Have No Fear ICD-10 Is Here
  - January 15-16, 2013
  - Register at: http://www.ihs.gov/RPMS/index.cfm?module=Training

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