Considerations When Planning and Implementing ICD-10 at Your Site

ICD-10 is comprised of two parts: ICD-10 Clinical Modification (ICD-10-CM) is used for diagnosis coding in all health care settings; and ICD-10 Procedure Coding System (ICD-10-PCS) is used for inpatient coding in hospital settings. Together, the ICD-10 contains over 155,000 codes.

- It is important to remember that implementation of ICD-10 will not replace CPT (Current Procedure Terminology) or HCPCS (Healthcare Common Procedure Coding System) codes for outpatient procedures and physician services. The IHS Resource and Patient Management System (RPMS) will continue to use CPT and HCPCS codes.

A key point for implementing ICD-10 is that providers will continue to select SNOMED CT (Systematized Nomenclature of Medicine Clinical Terms); however, there will be automated, software-based tools available to ensure documentation to best code in ICD-10 is provided from patient encounter data. The requirements for Meaningful Use Stage 2 introduced the use of SNOMED CT to document family history and the problem list.

- When ICD-10 is fully implemented, SNOMED CT terms selected by a provider will be translated internally through the RPMS EHR to ICD-10 and validated by coders for dates of service on and after October 1, 2015.

Another important component for successful transition to ICD-10 is clinical documentation. Accurate and descriptive clinical documentation is critical to support the SNOMED CT and mapped ICD-10-CM code selections and to provide coding staff with the information necessary to correctly apply the ICD-10 specific codes. The purpose of the SNOMED CT to ICD-10-CM map is to support semi-automated generation of ICD-10-CM codes from clinical data encoded in SNOMED CT for reimbursement and statistical purposes.

- With the ICD-10 implementation, the RPMS EHR will introduce Map Advice, which is produced and maintained by the National Library of Medicine to help providers and coders select the correct ICD-10 code based on the SNOMED CT term chosen and the clinical documentation. Map Advice is integrated into RPMS.

- Implementation of ICD-10 necessitates changes to most RPMS modules, although many of the changes are not apparent to the end user. For sites using IHS RPMS, implementing the 2014 Certified RPMS EHR is a requirement for ICD-10, even if your site is not planning to pursue Meaningful Use Stage 2 incentives.

Preparing for the ICD-10 implementation can start today with some practical steps:

1. Audit clinical documentation now to ensure that the following are documented:

   o Anatomical location, including laterality
   o Pregnancy trimester
   o Episode of Care
   o Acuity of condition – Staging, severity, etc.

2. Start this week with selected visits to dual code in ICD-9 and ICD-10.

3. Improve provider/coder query process today - queries may increase if documentation is not sufficient to support ICD-10 specific codes

4. Clear up claims processing backlogs, paying particular attention to incomplete or inaccurate visit, coding, or billing errors.

5. In January 2015, start the intensive training for coders

6. Start next week with identifying productivity impacts from provider/coder querying, coder learning curve, patient encounter delays, and any revenue impacts.

These steps will help you on your way to a successful ICD-10 implementation. More resources are available on the IHS ICD-10 Web site at http://www.ihs.gov/ICD10/. If you want to learn more about actions you can take to prepare your site for ICD-10, the site provides links to videos by the Centers for Medicare & Medicaid Services and presentations by the IHS and others, as well as training information. ICD-10 and the Integrated Problem List of the EHR were featured in a series of Clinical Rounds that can be found at http://bit.ly/TBHCEarchive.

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