ICD-10 Transition Readiness: What providers can do to prepare

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Objectives

- ICD-10 Opportunities
- ICD-10 Transition
- Staff Preparation and Training
- Clinical Documentation Improvement (CDI)
- Impact on Revenue
- Contact Information
ICD-10 Creates Opportunity

• **ICD-10 is proposed to:**
  - Enable Health Care Reform, ARRA, 5010, Pay For Performance (P4P)

• **Opportunities are endless:**
  - Clinical Quality/P4P improvement
  - Strategic Advantage
  - Complete, accurate information to drive healthcare reform

• **Readiness includes:**
  - Coordination/Integration between Payers, Providers, Vendors, Clearinghouses, Data Users
  - **Clinical**, Operational and Financial Process
  - IT integration between all trading partners
ICD-10 Transition Program - Summary

• IHS and all HIPAA covered entities are mandated to implement ICD-10.
• October 1, 2014 is the compliance date
• ICD-10 provides new procedures and diagnoses unaccounted for in the ICD-9 code set for reimbursement transactions and reporting purposes.
• ICD-10 includes anatomical location, trimester, episode of care, acuity of condition and other details not available in ICD-9
• ICD-9 codes do not translate directly to ICD-10 – IHS has mapped codes and is implementing taxonomies
CDI and Education – Key Strategies

• Provider *Profiling* for cost effective and high quality care continues
  • DRGs, Hospital Acquired Conditions, RAC audits, ACA, HITECH and Meaningful Use
  • And of course ICD-10 is a risk to the bottom line and some reporting

Stay on task with emphasis on timely CDI and Education to address risk
Clinical Impacts

Productivity impacts are expected

- Provider documentation may not be granular enough for ICD-10 (laterality, anatomic site, etc.)
- Increased physician queries for more information
- Coders will need more information in the record to support ICD-10 codes
- Learning curve for at least first six months
Financial Impacts

Productivity impacts are expected and may cause revenue shifts

- Dual coding may be necessary if a payer is not able to accept ICD-10 codes
- Denied claims
- Some coding productivity impacts may be permanent
Reducing the Impact

• Increased documentation is necessary to assign the most accurate code. Audit now for clinical documentation depth needed for ICD-10:
  • Anatomical location including laterality
  • Pregnancy trimester
  • Episode of Care
  • Acuity of condition – Staging, severity, etc.
  • Additional details for 5\textsuperscript{th}, 6\textsuperscript{th}, or 7\textsuperscript{th} character
ICD-10-CM Code Structure Example

Characters 1-3 is the Category: S52 Fracture of forearm

Characters 4-6 is the Etiology, anatomic site, severity, or other clinical detail:

S52.5 Fracture of lower end of radius (anatomic site)
S52.52 Torus fracture of lower end of radius (clinical detail & anatomic site)
S52.521 Torus fracture of lower end of right radius (laterality)

Character 7 is the Extension which provides additional information:

S52.521A Torus fracture of lower end of right radius, initial encounter for closed fracture

Requires greater specificity and supporting clinical documentation

ICD-10-CM Example of Granularity for Asthma

**ICD-9**
- Extrinsic Asthma with Acute exacerbation
- Extrinsic asthma with status asthmaticus
- Other, please indicate
- Unable to determine

**ICD-10**
- Mild intermittent extrinsic asthma with acute exacerbation
- Moderate persistent extrinsic asthma with acute exacerbation
- Severe persistent extrinsic asthma with acute exacerbation
- Mild intermittent extrinsic asthma with status asthmaticus
- Moderate intermittent....
- Severe intermittent..
- Other
- Unable to determine
Example of Pressure Ulcer Codes

ICD-9-CM 9 Codes
Pressure Ulcer Codes
• 9 location codes (707.00 – 707.09)
• Show broad location, but not depth (stage)

ICD-10-CM 125 Codes
Show more specific location as well as depth, including
• L89.131 – Pressure ulcer of right lower back, stage I
• L89.132 – Pressure ulcer of right lower back, stage II
• L89.133 – Pressure ulcer of right lower back, stage III
• L89.134 – Pressure ulcer of right lower back, stage IV
• L89.139 – Pressure ulcer of right lower back, unspecified stage
• L89.141 – Pressure ulcer of left lower back, stage I
• L89.142 – Pressure ulcer of left lower back, stage II
• L89.143 – Pressure ulcer of left lower back, stage III
• L89.144 – Pressure ulcer of left lower back, stage IV
• L89.149 – Pressure ulcer of left lower back, unspecified stage
• L89.151 – Pressure ulcer of sacral region, stage I
• L89.152 – Pressure ulcer of sacral region, stage II

Source: CMS ICD-10 Fact Sheet 8/2009
Reducing the Impact

- Providers should be a part of the ICD-10 implementation leadership – key for Clinical Documentation Improvement (CDI) & education
- Conduct documentation gap analysis (determine unspecified codes, top diagnoses and procedures)
- Promote **dual coding** of visits in ICD-9 & ICD-10
- Reinforce Provider/Coder relationship:
  - Timely Feedback to Providers on CDI
  - Assess current provider query process for ICD-10
  - Create opportunities for follow up/education
- Obtain ICD-10 CM and PCS Coding Books/Encoder
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 CT 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
Resources

• ICD-10 Website:
  • http://www.ihs.gov/icd10

• ICD-10 Prep Listserv:
  • http://www.ihs.gov/listserv/index.cfm?module=signUpForm&list_id=201
Resources
(IHS does not recommend – informational only)

• 3M CDI software
  

• HcPro Education
  

• AHIMA CDI Toolkit
  

• AAPC Provider training
  