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 5th, 6th, or 7th 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**)
S52.5**2** Torus fracture of lower end of radius (**clinical detail & anatomic site**)
S52.52*1* Torus fracture of lower end of right radius (*laterality*)

Character 7 is the **Extension** which provides additional information:

S52.**52*1*A** Torus fracture of lower end of right radius, **initial encounter** for closed fracture

Requires greater specificity and supporting clinical documentation

Source: "The Differences Between ICD-9 and ICD-10, Preparing for the ICD-10 code set", AMA. http://www.ama-assn.org/ama1/pub/upload/mm/399/icd10-icd9-differences-fact-sheet.pdf

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)

Source: CMS ICD-10 Fact Sheet 8/2009

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

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/listserver/index.cfm?module=signUpForm&list_id=201

Resources
(IHS does not recommend – informational only)

- 3M CDI software
- http://solutions.3m.com/wps/portal/3M/en_US/Health-Information-Systems/HIS/Products-and-Services/Products-List-A-Z/Clinical-Documentation-Improvement-Software/
- HcPro Education
- http://icd-10.hcpro.com/cdi/
- AHIMA CDI Toolkit
- http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_047236.pdf
- AAPC Provider training
- http://www.aapc.com/icd-10/physician-icd-10-training.aspx