Transitioning to ICD-10: What Leaders Need to Know

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Office of Information Technology
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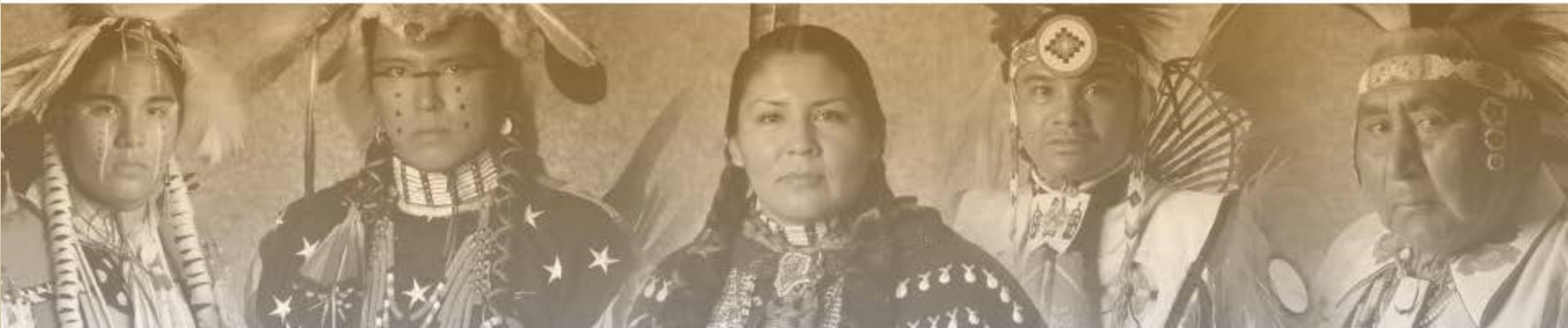
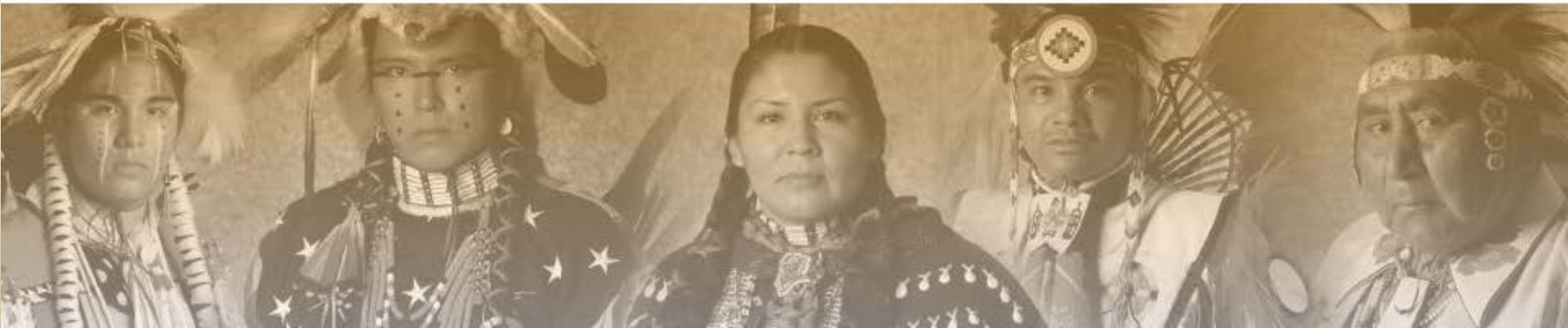
Urban Health Programs



Objectives

- ICD-10 Opportunities
- ICD-10 Transition
- Staff Preparation and Training
- Clinical Documentation Improvement
- 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 the International Classification of Diseases (ICD) 10th Revision (ICD-10) code set, updating from the ICD 9th Revision (ICD-9) per regulation enacted by the U.S. Department of Health and Human Services (HHS).
- The compliance date is set in regulation as October 1, 2014, a one-year delay from the original compliance date of October 1, 2013.
- ICD-10 provides new procedures and diagnoses unaccounted for in the ICD-9 code set for reimbursement transactions and reporting purposes.

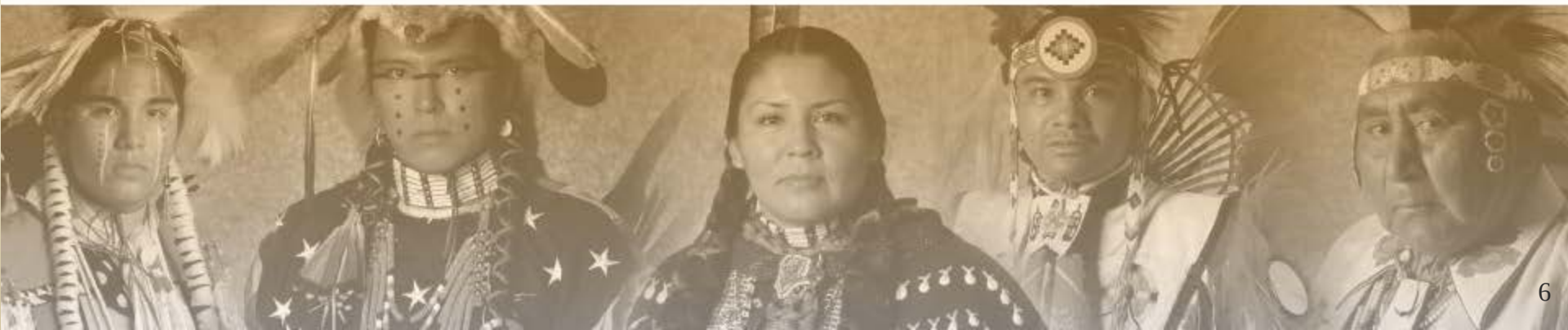
ICD-10 Transition Program - Summary

- Strategic management and planning, extensive system changes, specialized education, and effective training and implementation are essential to a successful transition.
- The process will require the Office of Information Technology (OIT) to significantly modify the Resource and Patient Management System (RPMS) to accommodate the new codes.
- All staff that utilize ICD-10, including providers, billers, coders and others, will be required to ensure not only an efficient implementation of the code set conversion software, but also an understanding of the documentation requirements and coding guidelines.

Global use of ICD-10

US Catching up with the industrialized world:

- Argentina, Austria, Australia, Brazil, Canada, Czech Republic, China, Colombia, Costa Rica, Denmark, Finland, France, Germany, Iceland, Ireland, Japan, New Zealand, Poland, Norway, Singapore, Sweden, Switzerland, Thailand, The Netherlands, UK, & Venezuela
- Canada: “Experienced between 32-50% reduction in coder productivity the first six months”
- Australia: “We wish we would have taken advantage of the time that we had!”



Have You Started The Transition?

- Steering Committee
  - Support and Leadership
  - Assess ICD-10 (users, systems, revenue, etc.)
  - Identify and Manage Milestones
- Identify an ICD-10 Coordinator
- Develop ICD-10 Expertise
  - Clinical Documentation Improvement
  - Impact on Revenue
- Training

Transition tools: IHS ICD-10, CMS, AHIMA Websites

Software Development

Milestone	Start Date	Baseline Due Date	Revised Due Date	Stoplight Status
Initiation	11/23/10	1/11/11	5/9/11	Complete – 100%
Planning	12/24/10	4/20/12	5/31/12	Complete – 100%
Requirements – P1	11/23/10	3/15/12	10/29/12	Complete – 100%
Design – P1	11/23/10	3/15/12	4/2/13	Green – 46%
Development – P1	11/23/10	5/1/13	11/5/13	Green – 49%
Testing – P1	3/23/12	5/31/13	11/15/13	Green – 18%
Implementation – P1	10/10/12	10/1/13	1/31/14	Green – 0%

Competing Priorities: Meaningful Use Stage 2, Certification of EHR, etc.

SNOMED-CT and ICD-10 in RPMS

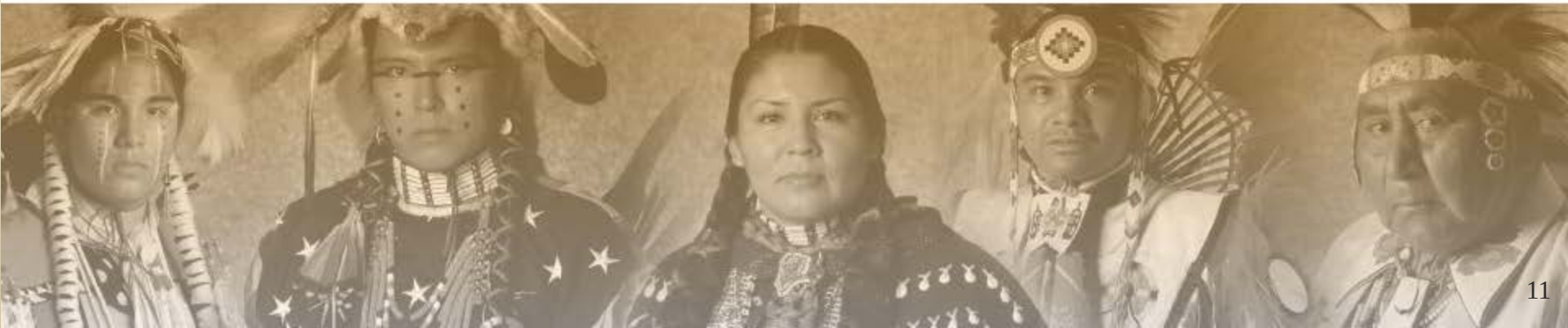
- Providers will select SNOMED-CT terms for Problem List, Purpose of Visit, Family History (and more)
  - Providers will select ICD-10 only if no appropriate SNOMED-CT term is found
- SNOMED-CT will be translated to ICD-10 by mapping tools (and/or coders) for billing and export to the data warehouse
- 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

Which EHR components use ICD codes?

- Problem List (SNOMED)
- Family History (SNOMED)
- Visit Diagnosis
- Historical Diagnosis
- CPT (associated diagnosis)
- Pick lists
- Superbill (associations)
- Clinical indications (labs, meds, consults, radiology in the future)
- Clinical Reminders (taxonomies, finding items, reminder dialogs)
- Immunizations
- Patient Education
- Reports
- Group notes (in development)
- Flowsheets (in development)
- Prenatal care module (in development)

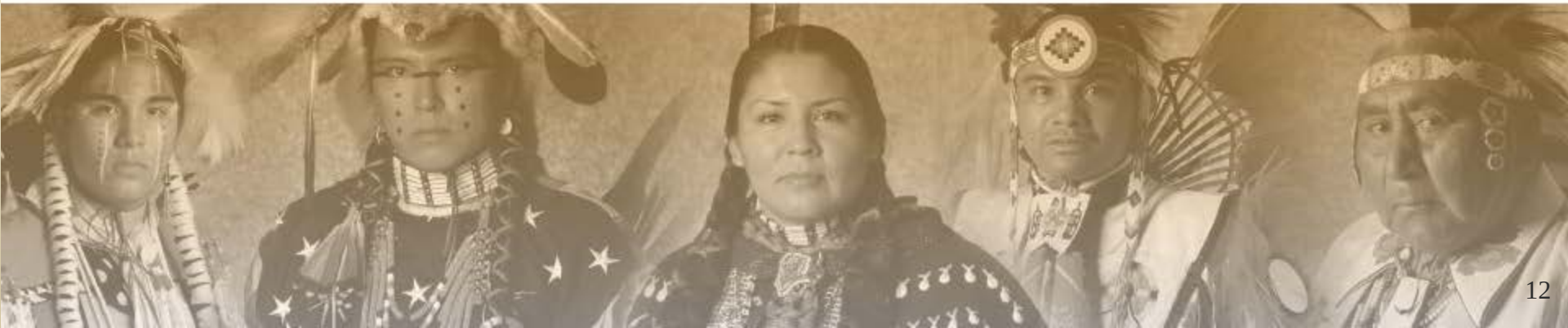
Engaging Providers in the ICD-10 Process

- Physician and other providers should be a part of the ICD-10 Steering Committee at the high/local levels
- Discussion on conducting a documentation gap analysis will occur
- Obtain local ICD-10 expertise: someone that has credibility with the provider(s) community and communicates well
- Foster the relationship between coders/providers



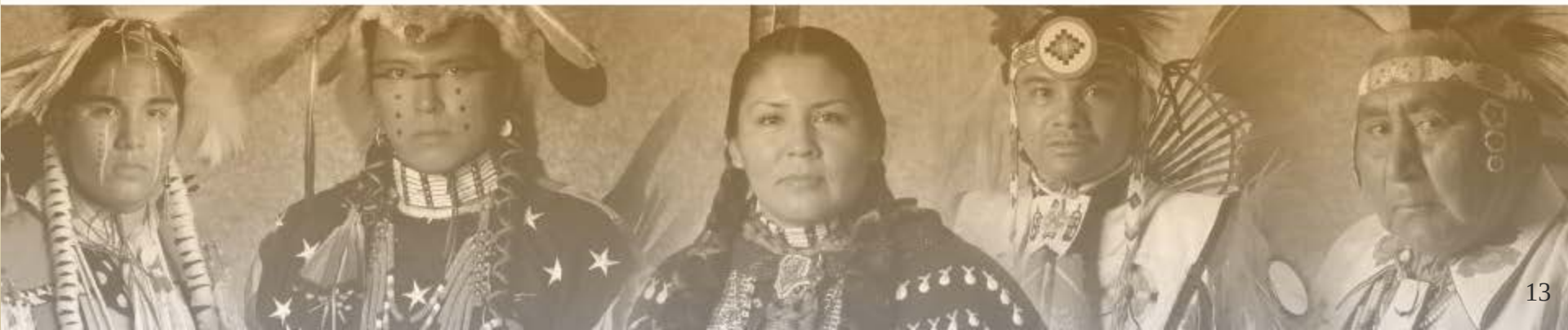
Staff Development

- Subject Matter Experts (ICD -10) are essential in the migration to ICD – 10
  - Critical to an accurate conversion
  - Industry wide demand for ICD -10 resources
  - IHS is gaining *some* ICD -10 expertise
    - Efficient use of ICD – 10 Subject Matter Experts
    - Training, Gap Analysis, CDI initiatives, local implementation



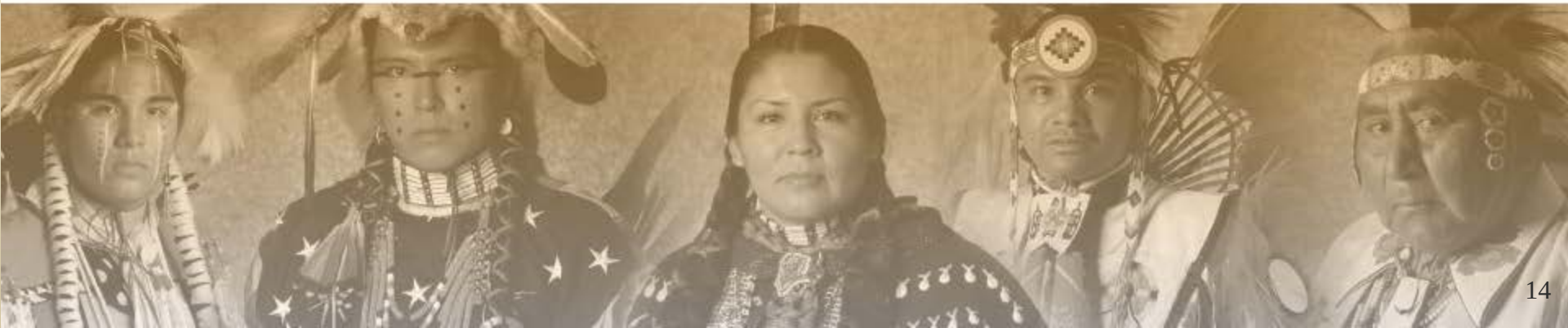
Have No Fear ICD-10 Is Here! Restructured…

- Minimize Travel
- Reach Urban and Tribal
- Reach remote sites
- CM and PCS separate sessions
- Coordination at the Area/Local Level
- CEUs available
- Introductory course
- IHS volunteer instructors
- Virtual Training



Training Schedule

- ICD-10-CM
  - January 9 – 10, 2013
  - April 10 – 11, 2013
  - July 10 – 11, 2013
- ICD-10-PCS
  - February 6 – 7, 2013
  - August 21 – 22, 2013



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

Steps to Begin Clinical Documentation Improvement Activities

- Identify Gaps in current documentation/coding to ICD-10
  - Run top DX report, review charts, feedback to providers
  - Start or expand on concurrent reviews
  - Share best practices (IPC test of change – coders in POD)
- Coding Feedback
  - Enhance Coder/Provider relationship
  - Create opportunities for follow up/education
- Obtain ICD-10 CM and PCS Coding Books

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

Comparison 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

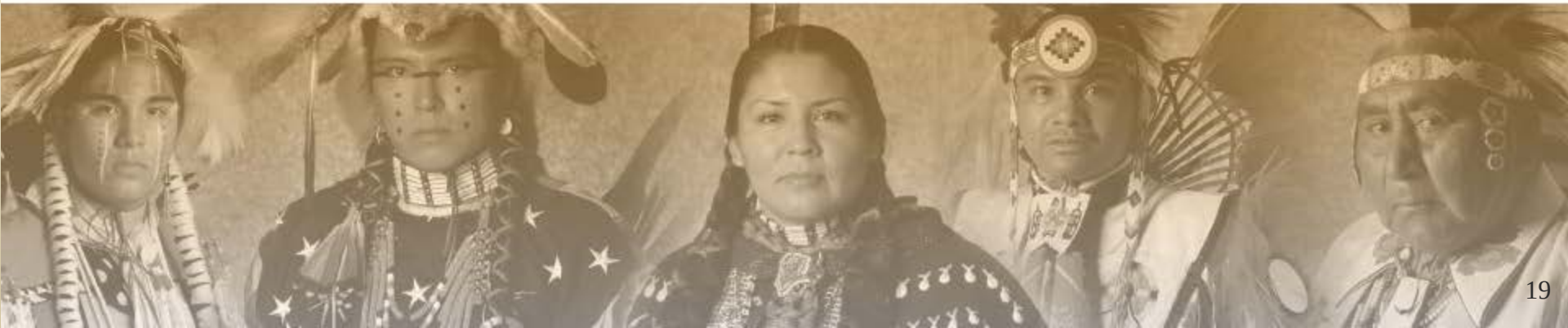
- L89.131 – Pressure ulcer of right lower back, stage I
- L89.132 – Pressure ulcer of right lower back, stage II
- L89.133 – Pressure ulcer of right lower back, stage III
- L89.134 – Pressure ulcer of right lower back, stage IV
- L89.139 – Pressure ulcer of right lower back, unspecified stage
- L89.141 – 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

Five Key Steps to Improving Clinical Documentation

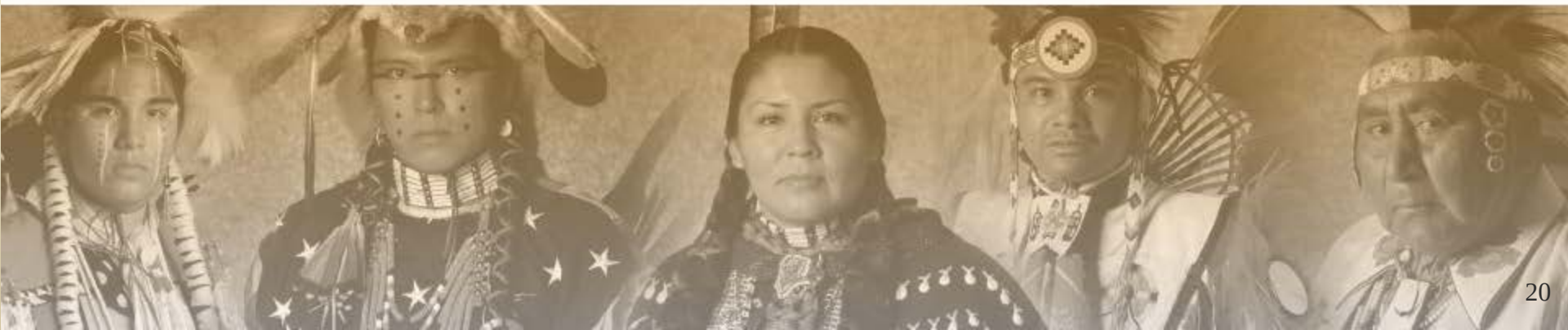
- Assess documentation for ICD-10 readiness
- Analyze the impact on claims
- Implement early clinician education
- Establish a concurrent documentation review program
- Streamline clinical documentation workflow

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



Summary

- Establish or recharge Steering Committee
- Obtain ICD-10 Knowledge
- Address Training
- Begin or enhance Clinical Documentation Improvement
- Understand Impact of ICD-10 on Revenue
- Be prepared for 10-1-2014



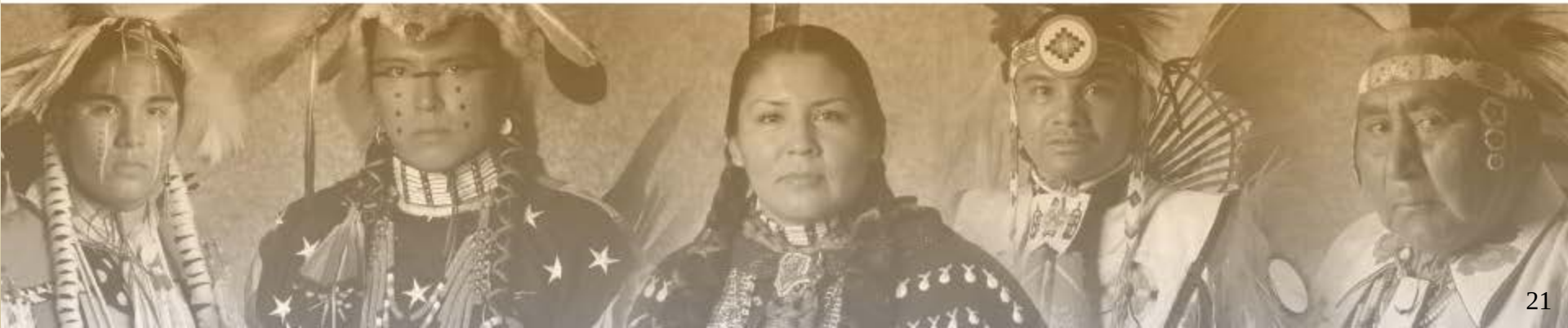
Resources

ICD-10 Website:

http://www.ihs.gov/icd10

ICD-10 Prep Listserv:

http://www.ihs.gov/listserver/index.cfm?module=signUpForm&list_id=201



Questions

Thank you!

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