Preparing for ICD-10 Implementation

A major coding change takes effect on October 1, 2014. Will you be ready?

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A big change in coding is coming in October 2014. ICD-10 (International Classification of Diseases, 10th Revision) is federally mandated to go into effect October 1, 2014. For Medicare, ICD-9 codes will no longer be recognized, and in order to get paid, it will be required to submit ICD-10 codes. There will be no grace period after October 1—submission of claims with ICD-9 coding will not be paid.

The update is necessary because ICD-9 cannot be expanded further to include newer or more specific diagnoses. ICD-10 codes will be alphanumeric, three to seven digits long (vs predominantly numeric codes three to five digits long for ICD-9), and will require different software to file claims. Some payers may still elect to use ICD-9 for special claims (eg, disability claims), so practices may need to determine whether they must keep the old software to file those outlier claims in addition to updating to new ICD-10-compatible software.

WHAT IS ICD-10?

ICD-10 has two components: ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) is the set of codes that all providers will use to designate medical diagnoses. ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System) is the set of codes that facilities use to report services, including procedures. CPT coding for physician services and outpatient procedures will not change or be affected by ICD-10.

ICD-9 went into effect in 1975. Ongoing refinement allowed the code set to remain in place for almost 30 years, but it can no longer be expanded as needed to reflect today's practice of medicine. Many other countries have adopted ICD-10 for several years, and there is impetus to adopt the same system in the United States to allow better data collection at a global level. Implementation in the United States has been delayed for several years, in part as an effort to stage it with other major mandated changes that have added administrative and financial burden for practices (eg, electronic health records [EHR] and changes connected with the Accountable Care Act.)

ICD-10-CM will include about 68,000 codes—five times more than the 13,000 codes that make up ICD-9. This expansion has allowed addition of newer diagnoses and increased reporting granularity. Much of the granularity of component CPT coding was lost with the bundling initiatives, and ICD-10 is expected to be a mechanism for collection of more granular data to allow tracking of procedures with outcomes. Some of the goals set for data collection with ICD-10 include:

1. Improved research ability, allowing analysis of outcomes of therapies;
2. More detailed quality reporting;
3. Improved data for analysis of quality, safety, and effectiveness;
4. More refined reimbursement (allowing billing for more complex care in sicker, high-risk patients);
5. Enhanced detection of fraud and abuse.

WILL I BE READY?

At this time, most practices should be implementing their plan to adopt ICD-10. There are many ways to do this, with multiple companies available to help with the transition. CMS, AMA, and some specialty societies have websites and tools to help physicians and practices with the changeover. What do physicians need to be doing?

Many physicians assume that their office administration or the hospital is taking care of the needed changes, but that is not always the case. The physician is ultimately responsible for compliance with the conversion deadline. If the physician cannot bill on October 1, no payment will be coming into the office.

Here are the basic questions you and your practice should be considering:

1. How will my claims be coded under ICD-10?

Physicians can help their coders by reviewing the ICD-10 list of codes and highlighting the ones most

likely to be used in their practices. Despite the large number of codes available, most practices will use only a small percentage of the total. A significant part of the expansion is the addition of separate right and left codes for many services. In addition, some services will require a different ICD code for initial visit versus follow-up visits for a clinical problem. There will not always be a 1:1 crosswalk from an ICD-9 code to an ICD-10 code, and your coders (and payments) will benefit greatly from some physician input. If your practice bills with superbills, updating the superbill to list the pertinent ICD-10 codes will be necessary.

Developing a basic understanding of the new codes will allow physicians to provide the documentation that the coders need to determine the correct ICD-10 coding. In theory, current documentation should be at a level that gives the clinical detail required, but because the level of detail in the codes has changed, greater detail may be required in some documentation. Awareness and familiarity with the new codes allows the physician to meet that level of documentation with each patient encounter, streamlining the billing and payment process.

2. Will I be able to complete medical records? Will my EHR system capture ICD-10 codes?

Existing EHR systems will likely require upgrades to accommodate the new codes. Validation testing of the system should be done prior to the go-live date, making sure that the ICD-10 codes are correctly captured internally. In addition to EHR systems, any other part of the practice that uses ICD coding will also need to be updated and tested. This includes software for billing, laboratory, procedure reporting, electronic prescription, and disease management registries.

3. Will I be able to submit claims?

Updating all of the internal systems to be compatible with and capable of reporting ICD-10 codes will be required. In addition to internal testing to be sure these systems are all functioning, external testing with entities such as the hospital, carriers, and outside laboratories will be necessary to be certain that communication will occur smoothly and accurately. The external entities are also required to make the updates to their systems.

4. Are coverage policies that affect my practice updated to reflect ICD-10?

If carriers do not update coverage policies, and coverage and payment remain tied to ICD-9 codes that are no longer submitted, it is likely that payment will be denied and inevitably delayed. Taking a look at those policies now and suggesting appropriate updates with all the applicable ICD-10 codes will help minimize delays and denial in payments. It would also be helpful to understand a carrier's specific rules regarding ICD-10 coding, such as whether they will accept claims with "unspecified" codes.

FAILURE WILL BE PAINFUL

The recent snafus with implementation of the Health Exchange website highlight the need for testing to be certain the system will work on October 1, 2014 and allow a smooth transition. If the system fails, either at a global level or at a practice level, the outcome will be a delay in payment. AMA has suggested that practices establish a line of credit in preparation for possible disruptions in cash flow. The transition will be an expensive investment for practices, but the goal for each practice is to get this right. Failure will be exceedingly painful. ■

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