

Update on the Transition to ICD-10

After a yearlong delay, the switch-over is finally happening—and your practice needs to prepare.

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The transition to ICD-10 coding is rapidly approaching. The changeover date is October 1, 2015. As of 12:01 am on that date, no bills will be accepted using ICD-9 codes. If you continue to bill using ICD-9 codes, you will not get paid. If you are not

already prepared, there is no time to lose in making preparations. This transition will require the coordination of all aspects of the practice to be successful.

ICD-10-CM (International Classification of Diseases, Clinical Modification, 10th version) is the set of codes used by both physicians and hospitals to report diagnoses. The other part of ICD-10 is ICD-10-PCS (International Classification of Diseases, Procedure Coding System, 10th version), which is the set of procedure codes used by hospitals/facilities to report procedures provided for patients. Physicians do not use ICD-10-PCS to report procedures, even if performed in a hospital and/or if the physician is a hospital employee. Physician procedural coding will continue to be through CPT coding. Therefore, ICD-10-CM is the set of codes physicians should understand and know how to use.

Failure to be ready to use ICD-10 codes on October 1, 2015 will likely result in severe financial impact to the physician/practice. There will be no grace period. If any part of the process fails, payments will not be made, and steps to recoup lost payments will likely be long and difficult. All carriers that are required to be HIPAA compliant will transition to ICD-10 (essentially all carriers with the exception of workman's compensation). Despite reliance on practice management and hospitals to do much of the preparatory work, the physician is still ultimately responsible for correctly coding bills. Coders will need physician input to be able to correctly report diagnoses, as well as clear documentation by all physicians to be able to report the correct ICD-10 codes. A physician champion in

each practice should be identified and trained to help with this transition, working with the coders and with other physicians.

Some ICD-10 codes may be cross-walked to ICD-9 codes, but that is not true for all codes. Even if coders use cross-walks available from various vendors, these may not be accurate and may lead to erroneous coding. There are about 55,000 more codes in ICD-10, with at least 700 new codes in the cardiovascular section. Despite assurances that most practices will not need to change documentation if they currently have excellent documentation practices, this may not be true in all cases. Physicians need to be familiar with the set of ICD-10 codes that will most commonly be used in their practices, and they will need to tailor their documentation to allow optimum coding. If details are lacking and coders use less specific codes, there may be payment penalties or nonpayment. In order to be able to collect and analyze data, health agencies need detailed data, and they may use payment as a means of increasing compliance for data reporting.

If a claim is filed with ICD-9 on or after October 1, 2015, or if a claim does not go through due to technical problems, there will be no payment. Failures could occur at multiple levels, and considerable work needs to be done before October 1 to be sure all aspects of the billing system are ready. Potential areas for failure and how to best prepare are listed below.

SYSTEMS AND PRACTICE FAILURE

ICD-10 requires upgraded software for billing. Most older software systems do not have the capacity to add the extra digits required for ICD-10. The software needs to communicate with the EHR system, patient registration software, carriers, hospitals/facilities, and other practices or entities to which you refer patients or from which you receive referrals. Even if your software is working perfectly, if other entities cannot receive

data from your practice or transmit to your practice, failures will occur. CMS and other entities are offering testing dates to help you determine that your systems are working. Take advantage of these opportunities and encourage possible occasions for entities that may not be offering them. (Remember implementation of the health care exchanges in 2013 and all the computer problems that limited access?)

PHYSICIAN/PROVIDER FAILURE

If physicians are not familiar with the new codes and are not aware of what needs to be documented in order for coders to select the appropriate ICD-10 code, they may not document the detail necessary for accurate coding. Clinical input is absolutely required. Help your coders be ready by giving them a list of the most commonly used ICD-10 codes for your practice. You will only use a small percentage of the entire ICD-10 code set, and preparing a list of the most common ones you use will allow your coders and physicians to focus on a small subset of important codes with which they should be familiar.

CODER FAILURE

If coders are not trained to use ICD-10, failure will almost certainly occur. Practices' investment in coder training is essential. It will take them longer to code, especially initially. There will be a learning curve as they convert, and longer codes require more keystrokes (more opportunity for data entry error). In addition, coders are charged with compliancy, and often will not report codes for services or diagnoses they cannot clearly determine from the medical record.

Physicians should interact with their coding professionals to maximize accuracy on both sides. Ongoing exchange of information and education will help improve coders' understanding of the clinical aspects of what they are coding. It will also help physicians understand how they can

ICD-10 RESOURCES

Many resources are available to help you manage this transition. Here are some examples:

- CMS website (www.cms.gov/icd10/)
- CMS website's "Road to 10" series of webcasts
- www.decisionhealth.com
- AMA website
- World Health Organization website (www.who.org)
- Many societies also have help for their members on their websites.

improve their documentation in order to capture payment for the services they are rendering.

CARRIER FAILURE

Carrier failure may occur if their systems are not ready to accept ICD-10 codes. It may also occur if all the local and national coverage policies in place are not updated to include ICD-10 codes rather than ICD-9 codes. If a coverage policy says that a procedure is only covered for diagnoses described by ICD-9 codes, all claims for that service will likely be denied once they are reported with ICD-10 codes.

ICD-10 CODING EXAMPLE

As an illustrative example of ICD-10 coding that may require documentation changes from current practice, consider coding for diagnosis of a patient with a foot ulcer due to atherosclerotic disease and ischemia.

To report this diagnosis using ICD-9, a single code is available:

440.23: *atherosclerosis of lower extremity with ulceration*

To report this diagnosis using ICD-10, there are 96

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TABLE 1. COMPARISON OF ICD-9 AND ICD-10

ICD-9 Diagnosis Codes	ICD-10-CM Diagnosis Codes
3 to 5 characters in length	3 to 7 alpha/numeric characters
Approximately 13,000 codes	Approximately 68,000 codes (700 new codes in cardiovascular section)
Limited space for adding new codes	Flexible for adding new codes
Lacks detail	Very specific
Lacks laterality	Requires laterality
Generic terms for anatomy	Detailed descriptions of anatomy
17 chapters	21 chapters

CODING & REIMBURSEMENT

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ICD-10 codes to consider, plus an additional code may be reported to identify the severity of the ulcer. There is also a large set of venous ulcer codes that the coder must consider if the record does not clearly document that the ulcer is arterial in nature. In order to select the correct ICD-10 code, multiple factors must be clearly documented:

1. Laterality: If the ulcer is in the right leg, a different ICD-10 code is reported than would be if the ulcer is in the left leg.
2. What type of vessel is diseased and contributing to the ischemia? The documentation should distinguish between native artery(s), unspecified type bypass graft, autologous vein bypass graft, nonautologous biologic bypass graft, nonbiologic bypass graft, and other type bypass graft. If the coder is not able to determine which of these is correct, he or she must resort to an unspecified code, which may not be paid.
3. The exact site of the ulcer should be specified. There are different ICD-10 codes for the following sites: thigh, calf, ankle, heel and midfoot, other part of foot, other part of lower leg, and other part of leg—unspecified site.

SUMMARY

ICD-10 transition is coming October 1, 2015. It is a drop-dead date with no grace period. If you or your practice are not prepared and cannot submit bills using ICD-10 on October 1, 2015, you will not get paid. Even if you are prepared, other factors may cause failure. The AMA has recommended that practices develop a line of credit to carry the practice if there is any type of failure resulting in nonpayments. Investment in preparation and education will minimize your exposure for failure. Physicians need to be part of the preparation and education to achieve success. The physician is ultimately responsible for billing their services. ■

Katharine L. Krol, MD, FSIR, FACR, is an interventional radiologist and has recently retired from active clinical practice. She has disclosed that she has no financial interests that pertain to this topic. If you have any questions you'd like Dr. Krol to address in a future column, please contact us at evteditorial@bmctoday.com.