Introduction to ICD-10

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Presented by:
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Sharp HealthCare
Corporate Compliance
Agenda

- ICD-10 Background & Overview
- Understanding ICD-10
- The Impact of ICD-10 on Everyone
- Detailed Ramifications of ICD-10
- Closing Thoughts
ICD Codes

- Created by the World Health Organization (WHO)
- **International Statistical Classification of Disease** and Related Health Problems Codes (ICD Codes)

**Benefits include:**
- Health Reporting, Quality, Research and Reimbursement

**ICD-9**
- Current coding system in the US since 1979
- Outdated, lacks sufficient specificity
- Running out of capacity
- Limited structural design
- Obsolete, no longer reflects current
  - Knowledge of disease processes
  - Contemporary medical terminology
ICD-10 Sits Among the Top Issues the Industry has to Weigh

Given the challenges and trends, it will be challenging to achieve uniform adoption of ICD-10 across the industry by October, 2013.
Major ICD-10 Changes

The Federal Government through the Centers for Medicare and Medicaid Services (CMS) is driving the healthcare industry to upgrade the diagnosis and procedure coding standards (ICD-10 by October 1, 2013.

![Graph showing diagnosis and procedure codes comparison between ICD-9-CM and ICD-10-CM for diagnoses and ICD-9-CM and ICD-10-PCS for procedures.](image-url)
ICD-10

- ICD-10 compared to ICD-9
  - More codes
  - More logically organized
  - More detailed descriptions of diagnoses and procedures
ICD-10 Requirements by Setting

- Physician
  - ICD-10 CM
  - CPT/HCPCS

- Hospital
  - ICD-10 CM
  - ICD-10 PCS
  - Inpatient
  - ICD-10 CM
  - CPT/HCPCS
  - Outpatient

- Behavioral Health
  - ICD-10 CM
  - CPT/HCPCS

- All Other
  - ICD-10 CM
  - CPT/HCPCS

- Long Term Healthcare
  - ICD-10 CM
  - CPT/HCPCS

- Laboratory
  - ICD-10 CM
  - CPT/HCPCS
ICD 10 Overview

- Mandated transition from ICD-9 to ICD-10 creates challenges for all health care entities
- Hospitals will see significant impacts
  - DRGs
  - Medical records documentation
  - Institutional procedure codes
- Payors
  - Medical policies
  - Adjudication rules
  - Risk prediction
  - Wide variety of analytics
Coding Challenges

• Code Structure
• Coding Rules
• Number of Codes
  • ICD-9-CM (diagnosis) = 14,432
  • ICD-10-CM (diagnosis) = 69,368
• Definitional changes
• Code detail
• Code sequencing and code relationships
• Categorization changes
*Each character has meaning – Build a Code
*Allowable value 4th through 7th characters in hundreds of tables.
The Basic ICD-10 PCS Change (Procedural Coding System)

The ICD-10-PCS procedural code set is designed to provide standardized terminology and expandability for procedure codes.

### Examples of ICD-10-PCS Structure

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Root Operation</th>
<th>Body Part</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Each can be either alpha (not case sensitive) or numeric (numbers 0-9 are used). Letters O and I are not used to avoid confusion with number 0 and 1.

**Examples:**
- 0FB03ZX Excision of liver, percutaneous on procedures
- 0DQ107Z Repair, esophagus, upper, open with autograft

**Advantages to PCS:**
- Provides detailed information on procedures
- Ample space for capturing new technology and devices
- Logical structure with clear, consistent definitions
Biggest Challenge with ICD-10?

- The change in terminology!
  - The PCS codes have very explicit terms for different character values
  - There are 31 root operations represented by the third character in the “Medical Surgical” section and each root operation is explicitly defined.
  - Every surgical procedure must fit into one of these root operations
# Coding – Changes in Terminology (PCS)

<table>
<thead>
<tr>
<th>ICD-9 Term</th>
<th>ICD-10 Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>….centesis</td>
<td>Drainage</td>
</tr>
<tr>
<td>Amputation</td>
<td>Detachment</td>
</tr>
<tr>
<td>Anastomosis</td>
<td>Bypass</td>
</tr>
<tr>
<td>Arthrodesis</td>
<td>Fusion</td>
</tr>
<tr>
<td>Arthroscopy, Cystoscopy…</td>
<td>Inspection…Endoscopic Approach</td>
</tr>
<tr>
<td>Aspiration</td>
<td>Drainage</td>
</tr>
<tr>
<td>Bunionectomy</td>
<td>Resection of Metatarsal</td>
</tr>
<tr>
<td>Caldwell Luc Procedure</td>
<td>Excision, Resection Right or Left Maxillary Sinus</td>
</tr>
<tr>
<td>Cesarean Section</td>
<td>Extraction of Products of Conception</td>
</tr>
<tr>
<td>Closed Reduction</td>
<td>Reposition (also repair) of (right or left), (percutaneous, endoscopic, external)</td>
</tr>
<tr>
<td>Colostomy</td>
<td>Bypass (Colon) to Skin</td>
</tr>
<tr>
<td>Debridement</td>
<td>Excision, Extraction, Irrigation, Exirpation</td>
</tr>
<tr>
<td>Incision</td>
<td>[No Comparable ICD-10-PCS Term]</td>
</tr>
<tr>
<td>Radical Mastectomy</td>
<td>Resection (Right, Left or Bilateral)</td>
</tr>
<tr>
<td>Subtotal Mastectomy</td>
<td>Excision</td>
</tr>
<tr>
<td>Tonsillectomy</td>
<td>Resection of Tonsils</td>
</tr>
<tr>
<td>Tracheotomy</td>
<td>Bypass</td>
</tr>
</tbody>
</table>
**Physicians**
- **Documentation:** The need for specificity dramatically increases by requiring laterality, stages of healing, weeks in pregnancy, episodes of care, and much more.
- **Code Training:** Codes increase from 17,000 to 140,000. Physicians must be trained.

**Clinical Area**
- **Patient Coverage:** Health plan policies, payment limitations, and new ABN forms are likely.
- **Superbills:** Revisions required and paper superbills may be impossible.
- **ABNs:** Health plans will revise all policies linked to LCDs or NCDs, etc., ABN forms must be reformatted and patients will require education.

**Coding**
- **Code Set:** Codes will increase from 17,000 to 140,000. As a result, code books and styles will completely change.
- **Clinical Knowledge:** More detailed knowledge of anatomy and medical terminology will be required with increased specificity and more codes.
- **Concurrent Use:** Coders may need to use ICD-9-CM and ICD-10-CM concurrently for a period of time until all claims are resolved and patients will require education.

**Billing**
- **Policies and Procedures:** All payer reimbursement policies may be revised.
- **Training:** Billing department must be trained on new policies and procedures and the ICD-10-CM code set.

**Managers**
- **New Policies and Procedures:** Any policy or procedure associated with a diagnosis code, disease management, tracking, or PQRI must be revised.
- **Vendor and Payer Contracts:** All contracts must be evaluated and updated.
- **Budgets:** Changes to software, training, new contracts, new paperwork will have to be paid for.
- **Training Plans:** Everyone in the practice will need training on changes.

**Nurses**
- **Forms:** Every order must be revised or recreated.
- **Documentation:** Must use increased specificity
- **Prior Authorizations:** Policies may change, requiring training and updates.

**Clinical Knowledge:**
- More detailed knowledge of anatomy and medical terminology will be required with increased specificity and more codes.

**Front Desk**
- **HIPAA:** Privacy policies must be revised and patients will need to sign all new forms.
- **Systems:** Updates to systems are likely required and may impact patient encounters.

**Lab**
- **Documentation:** Must use increased specificity
- **Reporting:** Health plans will have new requirements for the ordering and reporting of services.
Physicians

- For most physicians, coding is viewed as a “necessary evil.”
- Codes….are not generally considered a way of documenting or communicating the patient’s condition, but more so as tasks that need to be performed to ensure payment!
- Truth is…the operational disconnect between the coder and the physician results in suboptimal coding quality, which in turn results in inaccurate processing of insurance claims and unreliable or misleading data that may be used for clinical management or business operations analysis.
A new challenge, or a better situation?

- ICD-10 offers substantial improvements over ICD-9 in defining the patient’s condition.
  - Potential for better alignment between physician’s documentation and coding processes, the accuracy and efficiency of claim processing and analytics can be greatly improved under ICD-10
  - Amputation of finger
    - Today using ICD-9 procedure codes there is only a single code for amputation of the finger.
    - What about ICD-10?
**Example of Documentation Requirements**

<table>
<thead>
<tr>
<th>ICD-9 Procedure Code</th>
<th>ICD-9 Procedure Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>84.01</td>
<td>Finger Amputation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10 Procedure Code</th>
<th>ICD-10 Procedure Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>0X6N0ZO</td>
<td>Detachment at Right Index Finger, Complete, Open Approach</td>
</tr>
<tr>
<td>0X6N0Z1</td>
<td>Detachment at Right Index Finger, High, Open Approach</td>
</tr>
<tr>
<td>0X6N0Z2</td>
<td>Detachment at Right Index Finger, Mid, Open Approach</td>
</tr>
<tr>
<td>0X6N0Z3</td>
<td>Detachment at Right Index Finger, Low, Open Approach</td>
</tr>
<tr>
<td>0X6P0Z0</td>
<td>Detachment at Left Index Finger, Complete, Open Approach</td>
</tr>
<tr>
<td>0X6P0Z1</td>
<td>Detachment at Left Index Finger, High, Open Approach</td>
</tr>
<tr>
<td>0X6P0Z2</td>
<td>Detachment at Left Index Finger, Mid, Open Approach</td>
</tr>
<tr>
<td>0X6P0Z3</td>
<td>Detachment at Left Index Finger, Low, Open Approach</td>
</tr>
<tr>
<td>06XQ0Z0</td>
<td>Detachment at Right Middle Finger, Complete, Open Approach</td>
</tr>
<tr>
<td>06XQ0Z1</td>
<td>Detachment at Right Middle Finger, High, Open Approach</td>
</tr>
<tr>
<td>06XQ0Z2</td>
<td>Detachment at Right Middle Finger, Mid, Open Approach</td>
</tr>
<tr>
<td>06XQ0Z3</td>
<td>Detachment at Right Middle Finger, Low, Open Approach</td>
</tr>
</tbody>
</table>

* 20 more codes as there are 32 ICD-10-PCS codes for amputation of the finger which level and which surgical approach.*
New Documentation Requirements

ICD-10 impacts physician documentation requirements in both the office and hospital settings

• Reality: Considered an additional burden imposed by mandated federal requirements

• Practicality: Dramatic increase in codes
  • Equates to dramatic increase in documentation time and complexity
New Documentation Requirements
Reality Check

Key Points:
- Codes in ICD-10-CM are combination codes with considerable repetition of the same CONCEPTS.
  - Results in a large number of codes that are generally the same, with the exception of one or two concepts!
- Facts: About 25,000 (36%) of all ICD-10 codes are different only in that they distinguish “right” versus “left.”
  - Although there are lots of codes, there is a finite set of concepts.
New Documentation Requirements
Reality Check

• Key Points: Example
  • There are currently 33 ICD-9 codes related to a fracture of the radius
  • In ICD-10 there are ____ codes related to a fracture of the radius
  • A lot more codes in ICD-10 for the same condition and these codes do provide significantly more detail, but, there are really only about 52 distinct concepts in those ____ codes that repeat in patterns, resulting in this dramatic increase in the number of codes
New Documentation Requirements

• Key Points
  • Most of the new concepts introduced in ICD-10 codes are concepts that any physician should be documenting now
  • Extremely difficult to say that documentation of these concepts are unnecessary
    • They play a significant role in understanding
      ❖ Severity
      ❖ Risk
      ❖ Co-morbidities
      ❖ Causation
      ❖ Variety of other important parameters related to proper health care assessment and treatment
New Documentation Requirements

• Example: Definition of fractures through the growth plate
  • Very limited in ICD-9
  • ICD-10 includes codes that define growth plate fractures based on Salter-Harris I-IV classification
    • Long standing and widely used
    • Identifies significant differences in risk of deformity
    • Need for surgical treatment
• Unreasonable for a physician to claim that this classification is not an important part of clinical documentation or an unnecessary documentation burden
New Documentation Requirements

- Documentation requirements vary greatly by specialty or clinical domain
  - Codes related to ophthalmology have changed little in scope where as codes related to the musculoskeletal system have increased dramatically
  - Over 50% of the ICD-10 codes are related to musculoskeletal conditions
  - Over 17,000 ICD-10 codes (-25%) are related to fractures

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Finding the Right Codes

• ICD-10 poses considerable challenges in searching for the right codes to consider in any clinical scenario
  • The sheer number of codes in ICD-10 results in a commercial coding manual that is over 1,100 pages with very small type
  • The Alphabetical index, besides being large, is also difficult to navigate
Finding the Right Codes

- Example: In searching for a code based on the concept of “Coronary Artery Disease” + “Angina,” the user is redirected to other areas in the same document six times before finally getting to a reference code to look up in the Tabular Index.

- If the user now adds any other associated concepts like “post-bypass,” the search process is quite different.
Finding the Right Codes

• Without the use of a computer-assisted code search tools, office coders will struggle in trying to use traditional paper manuals.
Training

• The training requirements imposed upon coders will be significant
• Offsite training probably will be necessary given the amount of time to provide adequate instruction
• A train the trainer approach makes the most sense for many organizations, but investing in developing deep knowledge of ICD-10, can be challenging
Below is a full curriculum to prepare coders for the Oct. 1, 2013 implementation of ICD-10. All AAPC members and industry coders are strongly encouraged to consider all steps in the plan as each one provides the foundation for the next.
Coding Tools

• The challenges in dealing with the volume and complexity of ICD-10 codes generally will require the use of some form of coding tool
• Physicians (office’s) will need to assess their current coding practices and workflow in their practices to define the functionality needed in a coding tool
• Physicians and their practices will need to consider moving from manual to computerized coding tools if they have not already made that transition
• Current ICD-9 tools will need to be supplemented with new ICD-10 tools
  (During the transition and for some time thereafter, coding will need to support both ICD-9 and ICD-10)
Coding Tools

• The process of code searching will require different functionality and interface design to support the changes in ICD-10. (Merely updating an existing ICD-9 tool to also support ICD-10 probably will not be adequate)
  • Size, definition and structure will require a different approach
• Testing these tools with high volume, high dollar and high complexity clinical scenarios will be needed to assure that the needed functionality actually works as anticipated
• Different specialties or clinical domains will require different functional capabilities
Operational Impacts

• Each hospital and physician office will need to anticipate and plan for the operational impact that the transition to ICD-10 will impose.

• **Workflow Disruptions**
  • Workflow disruption before, during, and after the transition should be considered so that appropriate planning can be done to minimize the impact.

• Training will require time loss for key members of the team; some plan for backfilling or resources must be considered.

• Coding productivity will be significantly impacted.
Operational Impacts

- The Canadian experience suggests coder productivity (in a hospital setting) was negatively impacted by 50% (lasting one year).
- Initial challenges with coding accuracy, as well as payers struggles with processing during the transition, may result in increases in insurance claims being denied or paid inappropriately, requiring labor intensive reworking/resubmission of the claim.
- Physician productivity may similarly be impacted because of new documentation requirements and the increased physician querying that may be needed to support ICD-10 coding.
The SuperBill

- The Superbill as an instrument is used for collecting data for coding purposes and most likely will not be practical under ICD-10.
- Will force a major change in office workflow, particularly as patients check out of the office, where point-of-service billing information is needed.
The SuperBill

- Example: Although there are ___? codes for fractures of the radius in ICD-9, most orthopedic practices’ Superbills generally include only six codes or less.
- Coding often defaults to one of these codes, even though another of the other ___? codes might have been more accurate.
- Under ICD-10 there are _____? codes for fractures of the radius and there is simply not enough room to include these codes; plus the thousands of other relevant codes, on a standard Superbill.
The SuperBill

• *ICD-10 codes have much less in the way of general codes and in many instances force the use of very specific choices for a defined condition.*
Electronic Health Record Systems

• Many hospitals and physicians have or are acquiring Electronic Health Record (EHR) systems to modernize their operations.

• Much of this activity is driven by the HITECH stimulus provisions related to “meaningful use” of this technology.
Electronic Health Record Systems

- Unfortunately, the requirements for these systems to support ICD-10 coding in a “meaningful” way are lacking.
- Must be interfaces to support:
  - ICD-10 descriptions
  - Search for codes in a robust way that support the complexity of ICD-10 structure and new coding rules and definitions
  - Increased number of codes supported by the new 5010 claims transaction
  - Help in documentation to provide prompts for documenting critical concepts needed for coding based on the condition
Electronic Health Record Systems

• Example: If an orthopedist using an EHR system enters the condition of a fracture through the growth plate in a child, will the system prompt the physician that other concepts, such as:
  • “Salter-Harris classification”
  • Joint involvement
  • Displaced/non displaced
  • Level of healing
  • Other key parameters will be needed to accurately code this case
Business Systems

- Revenue cycle management systems for both hospitals and clinics will need to be updated to support coding in ICD-10.
- Need to be able to handle both ICD-9 and ICD-10 codes for quite some period of time after the implementation date, as claims with pre-implementation dates of service may still require ICD-9 codes.
- Some HIPAA non-covered entities, such as casualty or industrial injury claims processing entities, may still be using ICD-9.
Financial Impacts

• Some physicians believe that ICD-10 will have little business impact...because payments for their services are not directly associated with these codes.
• However, indirect impact may be a far greater concern.
• Invalid or inappropriate ICD-10 codes may result in denial of claims.
Cost of Compliance

- A substantial cost associated with implementation of ICD-10 by physician offices
- Costs may vary widely, and the actual cost for any physician practice will be difficult to assess
- Various studies have determined
## Cost of Compliance

<table>
<thead>
<tr>
<th>Category</th>
<th>Typical Small Practice</th>
<th>Typical Medium Practice</th>
<th>Typical Large Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>$2,405</td>
<td>$4,745</td>
<td>$46,280</td>
</tr>
<tr>
<td>Process Analysis</td>
<td>$6,900</td>
<td>$12,000</td>
<td>$48,000</td>
</tr>
<tr>
<td>Changes to SuperBills</td>
<td>$2,985</td>
<td>$9,950</td>
<td>$99,500</td>
</tr>
<tr>
<td>Information Technology Costs</td>
<td>$7,500</td>
<td>$15,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Increased Documentation Costs</td>
<td>$44,000</td>
<td>$178,500</td>
<td>$1,785,000</td>
</tr>
<tr>
<td>Cash Flow Disruption</td>
<td>$19,500</td>
<td>$65,000</td>
<td>$650,000</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>$83,290</strong></td>
<td><strong>$285,195</strong></td>
<td><strong>$2,728,780</strong></td>
</tr>
</tbody>
</table>
Claim Denials or Delays

- Given the challenges
  - Coding on the hospital and physician offices’ side
  - Remediation of processing rules on the payers’ side
- Significant increase in denials
  - Refinements in processing rules
  - Increase granularity of codes
  - Reliance on “crosswalks” to convert submitted ICD-10 codes (backward to ICD-9 codes)
- Unintended consequences
  - Misinterpretation of intent of policies
  - Artifacts of errors of translation of ICD-9 to ICD-10
Prior Authorization and Referrals

- Many prior authorization “triggers” or rules for evaluation, (found in payer’s systems) are based on ICD-9 codes
- Likely to be changes in how the prior authorizations are “triggered” or approved.
- Similarly, cases that require referral may be defined differently in ICD-10, based simply on migration from ICD-9 to ICD-10.
Auditing, Fraud and Abuse

- Recovery Audit Contractors (RAC), Medicare Administrative Contractors (MAC), Medicaid Integrity Contractors (MIC), Hierarchal Condition Categories (HCC), etc... fraud, abuse and other audits are increasing in depth and scope.
- To some degree the complexity of ICD-10 during the transition period may actually impede some audits initially.
- Little doubt, however, that the specificity and detailed level of information supported by these codes will result in much greater scrutiny of documentation to support these more detailed codes.
Strategies for Physician Engagement

- Success with the implementation of ICD-10 is dependent on improved coding as an initial requirement.
- Codes must accurately represent the health condition of the patient and procedures performed.
- Inaccuracy = all downstream processing and analysis will be suspect.
- Heavy reliance on physician documentation to provide basis for coding.
- Well trained, high quality coders is of little value if documentation is inadequate or inaccurate.
Strategies for Physician Engagement

• Critical to engage physicians in a way that aligns them with the importance of good coding, and their role in documentation

• Make the Case for Relevance
  • Impact on coverage, denials, authorizations, and other indirect financial impacts
  • Impact on the measure of the quality and efficiency on the services they provide
  • Value of high quality cross-enterprise data for the benefit of their patients
  • Future impacts on reimbursement
  • Impacts of audits for fraud and abuse analysis
Strategies for Physician Engagement

• Make the Case for Good Documentation
  • Beyond coding, good documentation is just good practice
  • New documentation requirements are not unreasonable
  • Consistent with best practices for medical assistant and decision making
• Find a Physician Champion
• Don’t Try to Turn Physicians into Coders
  • Physicians should focus on what they are trained to do
Strategies for Physician Engagement

• Don’t Try to Make Physicians Learn New Terminology
  • Physicians have a long history of using a language with which they are familiar
  • Good case for change in terminology over time
  • Can’t expect physicians to adapt to a new language
Strategies for Physician Engagement

• Coding professionals on the other hand are faced with a bigger challenge.

• Changes in the definition of terms for ICD-10-PCS will require the ability to rigorously adhere to the coding definition guidelines in ICD-10-PCS
  • May conflict with current documentation
  • May require interpretation and judgment by coders in assessing physician documentation in a way that is currently unfamiliar to most coders
Strategies for Physician Engagement

• Example: A physician may perform a procedure where he states that he “removed the right upper lobe of the lung.”
  • PCS however describe this as a resection.
  • *Resection* is defined as “cutting out or off, without replacement all of a body part.”
  • *Removal* is defined as “taking out or off a device from a body part.”
  • *Excision*, on the other hand, is defined as “cutting out of off, without replacement a portion of a body part.”
Anticipated Benefits of ICD-10 are Significant

Today’s data needs are dramatically different than they were 30 years ago when ICD-9 was introduced. ICD-10 will advance healthcare in many ways, with benefits accruing across following major categories:

<table>
<thead>
<tr>
<th>Quality Measurement</th>
<th>Data availability to assess quality standards, patient safety goals, mandates and compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Higher quality information for measuring healthcare service quality, safety, and efficiency</td>
</tr>
<tr>
<td>Public Health</td>
<td>Improved disease and outbreak information</td>
</tr>
<tr>
<td></td>
<td>Improved ability to track and respond to international public health threats</td>
</tr>
<tr>
<td>Research</td>
<td>Better data mining for increased analysis of diagnosis, treatment efficacy, prevention, etc</td>
</tr>
<tr>
<td></td>
<td>Recognition of advances in medicine and technology</td>
</tr>
<tr>
<td>Organizational Monitoring and Performance</td>
<td>Enhanced ability to identify and resolve problems and ability to differentiate payment based on performance</td>
</tr>
</tbody>
</table>

The benefits are significant, but it will require investment in changes to processes and technology across operations

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References

• CMS ICD-10 website
  – http://www.cms.gov/icd10provides
  – The latest ICD-10 information and links to resources

• AHIMA website

• CMS

• Sharp’s ICD-10 Project Share Point Site
  – http://socproj02/sites/projectserver 3399/ICD10%
  – 20 WebinarsSeminarsConferences/Forms/AllTerms.aspx
Thank you!

Questions?