ICD-10 Postcards: Canadians, Australians Share Experiences with ICD-10 Implementation

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by Chris Dimick

When people face a big change, they often call a friend for advice. It's natural to seek out those who have experienced a similar transition.

Many questions surround the implementation of ICD-10 in the US. Besides the big question of when the classification system will be required, HIM professionals are wondering how the transition will affect their jobs.

Approximately 100 countries use a form of ICD-10 for clinical morbidity coding. Two of those countries, Canada and Australia, have now been using a version of ICD-10 for years. Though the two health systems are not entirely similar to the US system, Canadian and Australian health information professionals still have much insight to offer when it comes to ICD-10 implementation. Consider the following insights some friendly advice from international colleagues who have worked through the major transition from ICD-9 to ICD-10.

Transition: Australia

Australia began discussing a transition to ICD-10-AM from ICD-9-CM in 1994. At that time, the Australian government established the National Centre for Classification in Health (NCCH) to create Australia's modification of the ICD-10 classification.

NCCH was also charged with providing training to the country's coders. Through a network of coding educators, NCCH presented 81 ICD-10-AM and Australian Classification of Health Interventions (ACHI) courses to 2,423 participants over 130 days. By July 1999, all eight Australian states had implemented ICD-10-AM.

A major challenge in the transition was getting long-time coders to embrace the change, says Catherine Perry, an NCCH trainer during the implementation and now the team leader of health and aged care in the information management strategies planning and resources branch with the Department of Human Services, Victoria, Australia. This is a struggle the US is sure to face as well, she says.

"One of the things to juggle is how do you bring those people who have been coding single classification for 20 years along," Perry says. "How do you not let them lose their grip on being the experts in classification?"

Though at times a hard sell, changing over to ICD-10 actually leveled the playing field for all coders looking to become experts. Some coders had never envisioned they would have to learn so much new information again in their career, Perry says. Not that there was much choice. "It is not like you could all move to Tasmania and keep coding in ICD-9 for the rest of your life," she says. "You had to go."

It helped that the ICD-9-CM and the base ICD-10 codes are similar in structure and content.

"If clinical coders have a good understanding of classification principles, then the transition is not difficult," according to Kerry Innes, associate director of NCCH, based in New South Wales, Australia. The transition to ACHI—Australia's procedural coding classification system—presented the greatest challenge to coders.

Learning ACHI required learning an entirely different classification, Innes explains. It is comparable to the US's intervention classification system ICD-10-PCS and CPT, though the two have different codes. "Productivity dropped a little due to the fact that coders were dealing with a very different procedure system and, of course, new codes for the diseases," Innes says. However, production returned to normal after about six months.

Transition: Canada

Like Australia, the steepest part of the learning curve for Canada's HIM professionals came in learning the intervention procedural classification, the Canadian Classification of Health Intervention (CCI), says Lori Moskal, CHIM.

Moskal, program lead of classifications for the Canadian Institute for Health Information (CIHI), was part of the team that developed the Canadian enhancements for ICD-10-CA. The HIM professional has experience working with ICD-9-CM and ICD-10-CA, and she has experienced the transition from the former to the latter.

The transition to ICD-10-CA in Canada began in 2001, with all Canadian provinces using the system by 2006. CIHI was responsible for developing Canada's enhancements of ICD-10 and the CCI, as well as for training the country on the new system.

CCI codes apply to any medical procedures done to a patient, such as surgeries or medical treatments. "The codes people were used to using in ICD-9-CM were just strictly numerical code structures. So, 99.99 was basically the highest code number that you could have," Moskal says. "But now, our intervention classification is an axial code structure that has five code components. So it is quite a bit different than what people were used to seeing."

The stress of relearning a profession was clear with some Canadian HIM professionals. "I think there is a natural resistance to change, and there certainly was a learning curve," Moskal says. A heavy workload only heightened the strain, she explains. "We are dealing with a shortage of coders across the country. So when you add on ten more minutes or perhaps a little bit more to code each chart in a hospital, that can have a significant impact."

Each coding professional attended a two-day CIHI workshop on the transition to ICD-10-CA and the CCI intervention classification. It was about six months to a year before people got back up to their old coding speed, according to Mea Renahan, MBA, CHE, manager of classification standards at CIHI.

"Now They Have the Codes"

Coders in Australia and Canada are finding the enhanced specificity in their versions of ICD-10 makes it easier to use than ICD-9-CM, say Innes and Moskal. ICD-10-AM and ICD-10-CA are much more specific, and they are now updated every few years.

The transition has made actual coding easier, Perry says. After the switchover from ICD-9 to ICD-10, "people went, 'Ah, this is how we can now classify the more complex things,'" she says. For example, ICD-10 features a code for SARS and other emerging diseases, an issue that was very real during the transition.

One of the challanges faced by coders in Canada was the introduction of new or revised coding rules by WHO, Renahan says. "There were some codes that for 30 years you were told to code in a certain way," she says, "then, in the new system, you are coding completely in the reverse." During training, these changes were reviewed, as were the higher-level change in code structure from numeric to alphanumeric.

Australia's NCCH knew it would get questions from coders after the switch. In order to answer them, it set up a centralized queries system to deal with the large volume of questions on the new classifications.

Using a more specific classification system made Australian coders look more closely at the documentation they were receiving, Perry says. This in turn led to better coding and better patient data.

A major overhaul of both countries' health information management systems was done as well during the implementation. Since ICD-10 uses an extra digit in its codes, both countries' hospital HIM systems had to be revised to accept the longer codes.

The changeover gave HIM professionals the chance to correct bad practices some had admittedly been doing for their entire career. "It was a great chance to purge those bad habits and go, 'OK, this is a brand new world, let's all start coding really well,'" Perry says.

Many Canadian coders were happy they now had new codes they could apply to procedures and diseases, Renahan says. For example, coders using ICD-10-CA have greater specificity in coding diabetes types. "They were really happy because they'd see all this information [in the chart], but they couldn't code it before because there was no code," she says. "Now they have the codes."

Different Countries, Different Challenges

There are differences in the Canadian and Australian health systems that make their implementations of ICD-10 unique from the eventual US experience. When Australia began implementation in the mid-1990s electronic information was less prevalent, and not all coders had computers on their desks, making training more complex.

The opposite was true of Canada, which implemented ICD-10-CA and CCI starting in 2001. Their mandate required the use of electronic coding systems alongside the implementation of ICD-10-CA. No paper versions of the new classifications coding books were even produced, and a computer coding system was installed on every coding professional's desk.

This presented a whole new set of challenges for those coders not used to working electronically, Moskal says. In fact, most health records departments in Canada at the time were not computerized, Renahan notes.

The electronic change was implemented during the ICD-10 changeover with the hope the technology would limit errors caused by people learning the new system. "The biggest challenge for the health information management professionals here was that transition from a paper world to a completely electronic one," Renahan says.

While some organizations in the US question the switch to ICD-10, Australia and Canada faced little to no resistance from the general healthcare industry. In Australia, some concern was raised by IT vendors, who faced required changes of their systems. But overall dissenting voices were quiet, Innes says.

The difference has to do with the way healthcare is managed in those countries. In Canada, for instance, the ICD-10-CA and CCI classifications were first implemented for morbity data collection in hospitals only.

Replacing the ICD-9 coding in other healthcare sectors and for physicians is moving forward more slowly. Canada has a single payer, the government. This is one reason why there was little resistance, Moskal notes. "We don't have the big payers here that are speaking out against it because healthcare is funded by the federal and provincial governments," she says.

Final Words of Advice

Though ICD-10 was an improvement on ICD-9, it is not the end-all classification system. Australian coders have begun to see some limitations in ICD-10-AM, limitations that couldn't be solved without "wholesale changes" to ICD-10, Innes says. Under its contract with the World Health Organization, Australia must limit its changes to ICD-10 in order to maintain the integrity of the underlying classification. Because of this, NCCH is beginning to discuss an eventual move to ICD-11, Innes says (though its release is still years away).

When ICD-10 does become a requirement, healthcare organizations should ensure that everyone to whom they send ICD-10 data is following the requirement, Perry says. Following the implementation, some entities in Australia still wanted codes to be delivered in ICD-9, confusing matters, she says.

The best advice for a smooth transition that Canada's Moskal can give US HIM professionals is to keep up on their knowledge of anatomy and keep up on their general coding credentials. "If people are well trained, there is no reason to worry about the transition to ICD-10," she says. "The actual act of coding is not going to change all that much."

The change can be managed with proper training, Perry says. But it requires understanding that changes affect more than the codes. A good transition begins with understanding how the change "affects the people, how it affects the systems," she says, from understanding "how we can prepare for this in advance."

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Article citation:

Dimick, Chris. "ICD-10 Postcards: Canadians, Australians Share Experiences with ICD-10 Implementation" *Journal of AHIMA* 79, no.3 (March 2008): 33-35.

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