Preparing for ICD-10-CM in Physician Practices

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What will change under ICD-10-CM, and what must be done to prepare? This is the year for physician practices to get their ducks in a row: become informed, assess their IT and training needs, and make a plan that leads to the October 1, 2013, deadline.

On September 30, 2013, after more than 30 years, the US healthcare system will assign its last ICD-9-CM code. The next day-October 1-ICD-10-CM and ICD-10-PCS will become the industry's required coding systems.

Physician practices will use only one of the systems, ICD-10-CM. The largest impact will be changes that are likely required to a practice's computer systems. Assessing systems early will be fundamental in keeping on top of the transition. Preparing staff and making a plan is the second key component.

Assessing Computer Systems

The switch to ICD-10-CM will affect both the practice management system and the electronic health record. In addition to billing, many computer system components or modules currently use ICD-9-CM codes as part of their logic. These systems may include patient problem lists, appointment or preventive intervention alerts, system interfaces or standard reports.[1] Therefore, determining the potential impact on the practice should start as soon as possible.

An impact assessment, including a system inventory, should be the first step a practice takes. AHIMA offers the "ICD-10 Preparation Checklist," which provides details of each phase from assessment through implementation.[2]

Some vendors may be ready to implement ICD-10-CM codes now, such as those who currently sell their product in non-US markets. Other vendors may not be ready now but plan on being ready by or before the deadline. Still others may not have plans to upgrade existing systems. Now is the time for practices to ask questions of the vendors whose systems they identify in the impact assessment.

Practices will not require additional technology to use ICD-10-CM, but the transition might be a good time to consider implementing technology to help with proper code assignment. ICD-10-CM will be available in book form; however, encoding software may improve accuracy of code assignment and provide the coder with code assignment tools that they may not now have, such as *Coding Clinic*, drug references, medical dictionaries, or official coding guidelines.

Practices should plan to maintain both ICD-9-CM and ICD-10-CM codes in their systems for some time. The exact length of time will be determined by the needs of the practice, with the greatest being the ability to resubmit unpaid claims with service dates prior to October 1, 2013.

In some special circumstances the practice may need to continue assigning ICD-9-CM codes. A practice's special services may make dual coding desirable, such as participation in clinical trials or other research studies where dieseases must be tracked consistently over long periods of time.

What's Changing-A Quick Overview

An Outdated Code Set Is Retiring

The change is necessary and overdue. ICD-9-CM was developed in the 1970s, and it no longer describes medicine in the twenty-first century. After 30 years, the system is running out of codes, and a limited structural design prevents it from adding more. In addition, ICD-9-CM was never intended to be used for reimbursement, even though it soon became employed for that purpose. Finally, with the rest of industrialized nations using ICD-10–based systems for morbidity coding, the US is unable to make accurate comparisons about disease patterns around the world.[1]

Physicians Will Use Only Part of the New System

Physician practices will use only ICD-10-CM. They will *not* use ICD-10-PCS, the procedure coding system. Hospitals will use ICD-10-PCS to report the resources they use in treating hospital inpatient cases. Physician services delivered in any setting will continue to be coded using Current Procedural Terminology (CPT) and the Healthcare Procedural Coding System (HCPCS).

The Systems Are Similar, Yet Still Very Different

Longer alphanumeric codes. All ICD-10-CM codes are alphanumeric, not just the supplementary classifications (V codes) and causes of injury (E codes) that are found in the ICD-9-CM system. In addition, ICD-10-CM codes can be up to seven characters in length, rather than the previous limit of five.

Many more codes with far more specificity. The number of codes increases from about 13,000 to 68,000. However, physicians will not use them all. Most physicians use a relatively small number of diagnosis codes related most closely to their specialty.

Nonspecific codes are available in ICD-10-CM, as they are in ICD-9-CM. This will allow coders to assign codes even when specific documentation is unavailable. However, detailed documentation will allow physician practices to take full advantage of the information that can be conveyed by the new, detailed codes.

There has been considerable discussion about whether physician documentation contains the information necessary to assign ICD-10-CM's more specific codes. An AHA and AHIMA field-testing project completed in 2003 showed that much of the detail is present.[2] Codes were easily assigned to physician documentation during the field-testing process.

The increased specificity in ICD-10-CM means that codes are easier to assign correctly, because there are fewer ambiguities. This should result in fewer coding errors and fewer unpaid claims and noncoverage issues. The specificity of the codes should decrease the requests for submission of additional supporting documents on many claims.

Structural changes in the organization and categorization of diseases. ICD-10-CM is structured differently. In addition to the longer, alphanumeric code structure, it describes diseases differently. Specialty societies have been providing input into the codes and newer, more appropriate terminology has been included. For example:

- Hypertension is no longer split between benign and malignant. It has one code, I10, which describes essential (primary) hypertension and includes the diagnostic statement of high blood pressure.
- R00 through R99, Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified, replaces the current 780–789 codes in ICD-9-CM. This new category has been expanded to include hundreds of codes. For example, abdominal pain will now be coded differently from acute abdomen, abdominal tenderness, and colic, which were all previously described with category 789.0x.
- In the category for osteoarthritis, ICD-10-CM codes M19.01–M19.93, unspecified locations, are no longer grouped with the specific locations for each type (the familiar .9 code in most ICD-9-CM categories). They are now found at the end of the code grouping (M19.90–M19.93) for each specific type, but in an unspecified location. In addition, traumatic osteoarthritis is now more appropriately indexed and described as posttraumatic osteoarthritis, the true condition.

One code, not two, for many complex conditions. Professionals in coding and reimbursement, especially superbill developers, will see a benefit in the increased use of combination codes. For years, superbill developers have had trouble ensuring correct data entry when diseases required two codes, such as diabetic neuropathy. In ICD-9-CM, codes 250.60 and 357.2 are required, with a requirement that 250.60 be listed first. In ICD-10-CM, code E11.40 describes this with just one code. This simplifies forms development by conforming to usual one-line-per-entry method of creating superbills.

While these superbill sheets of pre-assigned codes can speed physician charging, it should be noted that assigning codes directly from the documentation is viewed as the best practice and is in the physician's best interest. By design, superbills can limit the number of codes that are available for selection and can cause the physician to bill codes that are not supported by actual medical record documentation.

Notes

1. AHIMA. "Why is ICD-9 Being Replaced?" Available online at www.ahima.org/icd10/.
2. American Hospital Association and AHIMA. "ICD-10-CM Field Testing Project: Report on Findings-Perceptions, Ideas and Recommendations from Coding Professionals across the Nation." September 2003. Available online at www.ahima.org/icd10/.

Preparing the Practice

Practices can gain from preparing to get the most benefit from the new system, rather than just complying with the implementation. Now is the time to inform key personnel and identify a physician champion for the project.

Now is also the time to determine who in the practice is best qualified to become the ICD-10-CM content expert, such as a coding supervisor or a lead coder who is very familiar with ICD-9-CM. This person should receive training about the ICD-10-CM format and how ICD-10-CM works so he or she can be involved in the impact assessment and transition planning process. The content expert should be the first person to receive training on how to assign ICD-10-CM codes, possibly within the next one to two years.

The content expert may be able to serve as the project leader for the implementation; however the practice may require a dedicated project leader to ensure that current processes run smoothly while implementation stays on track.

Solo or small practices must determine if their staff will have the time to accomplish the transition. If not, they will require some level of help from outside the practice. The decision will depend in part on the practice's current use of IT and the nature of its strategic plan for IT over the next three to five years, because the transition will have the greatest impact on computer systems.

Practices should not rush off to train the entire coding staff; it is too early for that. However, it is a good time to assess each coder's current level of anatomy and physiology knowledge, because ICD-10-CM could require more than they may have needed previously. If coders will use new technology to help with ICD-10-CM code assignment, this would also be a good time to inventory their computer skills.

An Initial Look at Skills Development, Documentation Improvement

The time between now and 2012 can be used to implement a skills development program for areas such as anatomy and physiology, disease pathology or pharmacology, and enhancement of computer skills that might be needed as new systems are implemented. Provide general information now about the upcoming changes and what to expect. Keep the staff informed about what the plans are.

Coding staff can begin training in the actual use of ICD-10-CM and the associated guidelines in 2013-a time frame of six to nine months prior to October 1 will be best for hands-on training. Practices should avoid training physician practice coders with hospital coders, because the areas of concentration will be entirely different for the two groups. Physician practice coders

should be trained in groups from a similar specialty, if possible, and with training materials customized for the physician practice environment.

These same concepts apply for the physicians in the practice. They will benefit from general information early and more detailed information based on their role in the practice later.

The practice's ICD-10-CM content expert should attempt to determine if documentation improvement might help the practice. While improvement may not be necessary, this would be the time to develop physician skills in documenting information to help in correct code assignment.

For example, orthopedic physicians who treat automobile accident injuries and workplace injuries might benefit from learning to document about whether this is the initial versus a subsequent encounter or whether the condition is a sequela. This coded information, along with the coded cause of injury information, could speed claims payment and reduce the number of requests for additional information from payers. Now is the time to develop the documentation habits that will help the practice code more effectively, both now and in the future.

Superbills will also need attention, but there should not be a need for major changes in this area. Superbill entries simply need to be recoded using ICD-10-CM. However, it is advisable that practices wait several years before doing this, because ICD-10-CM is still being revised. Every annual code change made to ICD-9-CM is being mimicked in ICD-10-CM. Therefore, the final version that is implemented in 2013 will look slightly different than the current version.

It is anticipated that the Coordination and Maintenance Committee that maintains ICD in the US will "freeze" the code set sometime within the 12 to 24 months leading up to implementation. This would allow sufficient time for coding updates to take place. For now, creating a sample superbill with the new ICD-10-CM codes should be sufficient for use in discussions with physicians and staff.

October 1, 2013, may seem like a date in the distant future, but don't be fooled. There are steps that every physician practice should be taking to make the transition to ICD-10-CM go smoothly now and over the coming years.

A Physician Practice Timeline for ICD-10-CM

Now

- Download and read AHIMA's "ICD-10 Preparation Checklist" (www.ahima.org/ICD10)
- Identify and appoint a physician champion
- Identify and appoint an ICD-9-CM/ICD-10-CM content expert
- Identify and appoint a project leader
- Establish an interdisciplinary steering committee

2009–2010

- Work through the recommendations presented in the preparation checklist
- Inform all physicians of upcoming changes and the practice's implementation plans
- Inform all staff of upcoming changes and the implementation plans
- Assess skill levels of staff for future needs
- Assess documentation improvement needs

2010–2012

- Provide periodic updates on the implementation's progress
- Implement any necessary skill development or enhancement programs for staff and physicians
- Continue to work through implementation plans

2013

- Provide hands-on training for staff using materials designed for physician practices
- Complete implementation plans and prepare for go-live on October 1

Notes

1. Rose, Eric. "Preparing for ICD-10-CM: A Clinician's Perspective."*Journal of AHIMA* 80, no. 7 (July 2009).
2. Bowman, Sue, and Ann Zeisset. "ICD-10 Preparation Checklist."*Journal of AHIMA* 78, no. 6 (June 2007).

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