Strategies for Navigating the Approaching Wave of New ICD-10 Codes

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Before many health information management (HIM) professionals feel fully confident that they have the new ICD-10 codes under control, they should know that there are more on the way. More than 5,500 new procedure and diagnosis codes will go into effect beginning in October 2016, following a partial freeze of new codes that was designed to help facilitate last year's transition to ICD-10.

What does this mean for HIM teams still feeling the effects of implementing the original 70,000-plus ICD-10 codes? How can you prepare your organization and minimize the impact of the new codes on your team's efficiency—and sanity? The following are some strategies consultants have seen HIM professionals from around the country employ as they prepare for this next wave of ICD-10 codes.

First of All, Don't Panic!

While the thought of integrating 5,500 new codes at once sounds daunting, it's not as big a challenge as it may seem. The majority of the new codes (3,651) are for inpatient procedures, 97 percent of which are for cardiovascular procedures.

In many cases, these new codes provide additional detail to existing procedures, including codes for specific devices and things coders were likely already looking for. On the diagnostic side, many of the new codes cover combinations, such as diabetes comorbidities and additional specificity for coding cancers. This reality narrows the impact to specific service lines, which should help simplify training.

Assess the Impact Now

HIM professionals should, if they haven't already, review the new ICD-10 codes at the Centers for Medicare and Medicaid Services (CMS) ICD transition web page to assess how they may impact one's organization. Some questions to answer are: "How big of a deal are these codes and will they impact quality, reimbursement, coder productivity? Is a new code simply rewording an existing procedure or is it introducing new elements that may lead to more queries?

Only a detailed assessment will enable an HIM professional to answer these questions. Performing that assessment now will help HIM target its training and education activities to those that will be most impacted in light of one's organization's services and case mix. As noted, if your case mix does not include cardiovascular procedures, the impact will likely be minimal.

Audit Your Accuracy

How accurate is your ICD-10 coding to date? Making certain you have effective quality audit procedures in place is even more critical as the new codes come online. Many organizations take a focused approach to auditing, pulling individual charts to confirm they have been coded correctly. Reviewing any denials as a result of incorrect coding is another fundamental audit activity that HIM professionals should start now if they are not already doing it.

Another step to consider is reviewing care manager notes to see how specific diagnoses or procedures are worded in order to identify potential misalignments with the coded records. The goal is to identify gaps and patterns that will enable HIM to focus training on key trouble areas.

Leverage Technology

As the number of codes expands, the need for technology to help ensure accuracy and streamline processes becomes even greater. Computer-assisted physician documentation (CAPD) technology can help ensure physicians include the diagnostic and/or procedure details necessary to improve coding accuracy and reduce time consuming queries.

Forward looking organizations are also leveraging analytics to help optimize their coding processes. Analytics can be used to identify records for auditing, improving efficiency while effectively targeting areas in need of improvement. As the number of codes expands, increasing complexity, using automated intelligence to support human review will become more important. For now, it is advisable to contact the facility's EHR vendor to ensure their encoder will be updated and ready for use on October 1, 2016.

Commit to Continuous Education

The arrival of new ICD-10 codes is a reminder that training is not a one-time event. Continuously evaluating coding procedures and providing education to improve accuracy and efficiency are vital. This means not only training for the new codes, but also reviewing existing ICD-10 codes that may be causing difficulties.

It's important that coders understand what a procedure actually involves. For example, one ICD-10 code is for a leadless pacemaker, as opposed to a traditional wired pacemaker. Since the leadless pacemaker qualifies for a higher reimbursement, ensuring that coders understand the difference can have a significant impact on revenue. Don't wait until problems arise—try to anticipate codes with the potential for confusion and focus training on these. The industry can expect more new and revised codes in the future. Establishing a robust, ongoing education program will help keep an organization ahead of the curve.

Work Collaboratively

A collaborative approach to ensuring the accuracy of coding is more important than ever. That means maintaining close collaboration between documentation specialists and coders within the context of a clinical documentation improvement (CDI) program. Working together, documentation specialists and coders can identify where any problems may exist through the entire documentation lifecycle.

How important is this process? Take for example one of the author's clients, who found that collaboration between their documentation specialists and coders led to coding changes that resulted in $1.6 million in reimbursements that otherwise would have been missed. That's compelling evidence of the value of collaboration—and the value of promoting a culture where everyone recognizes they are on the same team, working toward the same goal.

The influx of new ICD-10 codes can be viewed as an opportunity: a chance to improve your HIM processes and sharpen your team's skills. But don't wait to get started—the wave is fast approaching.

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