ICD-10-CM-PCS

ICD-10-CM/PCS

ARE YOU PREPARED?

Executive Summary

Meeting the criteria for incentive funds to adopt electronic health records (EHRs) and achieve meaningful use under the American Recovery & Reinvestment Act (ARRA) is a primary focus of many healthcare organizations; however, there is another significant, high-risk reform initiative that is not getting the awareness and consideration necessary for a successful transition.

The use of ICD-10 code sets, already in use by other developed countries around the world, has been mandated by the United States Government starting Oct. 1, 2013. The regulation requires that claims won't be accepted with ICD-9 codes for outpatient services with dates of service on or after Oct 1, 2013. Likewise inpatient claims will not be accepted with discharge dates on or after Oct 1, 2013. The new standard for diagnostic coding under this regulation is the U.S. version of ICD-10; ICD-10-CM2. The new standard for institutional procedure codes is ICD-10-PCS3.

A prerequisite to the ICD-10 transition is the migration from existing Electronic Data Interchange (EDI) transaction standards to the new ANSI X.12 version 5010.

Diagnosis and procedure codes are essential to treatment and payment processes in today's healthcare industry. Although the codes change yearly, changes have been minimal in nature and have been made by accommodating new medical disorders or treatment procedures within the current ICD-9 manuals.

ICD-10 however, is a colossal renovation of the coding scheme and will require field size expansion, change to alphanumeric configuration, and complete redesign of code values and their interpretation.

Inevitably, this will be the most significant change in medical coding since its inception.
Due to the difference in the number of codes within a set "crosswalks" with a one-on-one match will not be available in most scenarios due to the eight-fold expansion of code sets.

An estimated 20,000 diagnosis and procedure codes in ICD-9 will expand to greater than 155,000 in ICD-10. These codes are used not only for analytic and reporting purposes; they are ingrained in most business processes. They factor into pricing, payment, contracting risk prediction, and a variety of other mission critical business functions. Rules, categorizations, and a variety of edits and algorithms to support many different business functions use these codes either as table look ups or as hard coded logic in existing systems Virtually all aspects of healthcare business: financial, clinical, operational and organizational will be impacted.

Disruptive in the short term, ICD-10 transition will provide many long-term positives. More precise diagnosis information will benefit not only patient care through improved care documentation, but will also improve business intelligence in care delivery, claims processing and payment through the availability of greater detail.

Now is the time to start preparing for the conversion. You will need to educate almost everyone within your organization. This paper highlights the considerations that are essential before any new coding standard should be adopted.

Background

Current State

ICD-10 codes are imbedded in business processes and are used for analytic and reporting purposes as well as influencing price, payment, contracting risk prediction, and a variety of other vital business functions. Rules, categorizations, and a mixture of edits and algorithms to support many different business functions use these codes either as table look ups or as hard coded logic in current systems

Today, the International Classification of Diseases – 9th Edition, Clinical Modification (ICD-9-CM) is the clinical code set based on the World health Organization's (WHO) International Classification of Diseases used to report the diagnoses or diseases and procedures of patient encounters. ICD-9-CM includes both diagnosis and procedure codes. ICD-9-CM diagnosis codes are used in essentially all healthcare settings to include the outpatient, inpatient, physician's office, long term care, and home health settings. ICD-9-CM procedure codes are used primarily in the inpatient institutional (hospital) setting, although some payers require the use of ICD-9-CM procedure codes in the outpatient setting.

The (WHO) established ICD as the method for compiling mortality and morbidity data in 1948. Modifications adopted by the WHO Assembly become the approved standard. Revisions to the ICD are made by the National Center for Health Statistics for the diagnostic codes used in the United States.

The procedure classification in ICD-9-CM is created and maintained by the Healthcare Financing Administration (HCFA). The U.S. adopted the use of ICD-10 for mortality data on January 1, 1999. In June 1997, the National Committee on Vital and Health Statistics recommended industry adoption of ICD-10. The ICD-10, as developed by the WHO, does not include a section on procedures. HCFA contracted with 3M to develop ICD-10-PCS for procedures.

Current Procedural Terminology (CPT-4) is used for procedure coding in the physician office and outpatient institutional (hospital, ambulatory surgical center) setting except as noted above for certain payers.

Why change?

The ICD-9 system is over 30 years old and does not have the flexibility to meet current healthcare changes and requirements for more meaningful information. The use of ICD-9 coded data has grown far beyond the originally intended purpose. The current code set does not provide the reporting specificity needed to fully describe a disease state and procedure, nor do they support the detail needed for data collection and reporting.

Another issue with ICD-9 is that some chapters are full and impede the ability to add new codes. In some cases, new codes have been assigned to different chapters making it difficult to locate all available codes, resulting in uncertainty in the coding process.

What are the differences?

The transition will include major changes in the structure of the codes, coding rules and terminology. Greater specificity will require more complete documentation.

ICD-10-CM

- 14,300 ICD-9 codes to 69,000 ICD-10 codes
- Expanded injury codes in which ICD-10-CM groups injuries by site of the injury, as opposed to grouping in ICD-9-CM by type of injury or type of wound
- Creation of combination diagnosis/symptom codes, which reduces the number of codes needed to fully describe a condition

- Greater specificity in code assignment (up to seven characters)
- Laterality - ICD-10-CM code descriptions include right or left designation
- V and E codes being incorporated into the main classification in ICD-10-CM
- ICD-10-CM codes being alphanumeric and including all letters except U
- The format (ICD-10) differs from the Ninth Revision (ICD-9) in a number of ways:
    - ICD-10 has alphanumeric categories rather than numeric categories
    - Some chapters have been rearranged and titles changed as well as conditions regrouped
    - Almost twice as many categories as ICD-9

ICD-10-PCS

- 3,800 ICD-9 procedure codes to 72,000 ICD-10 procedure codes
- Major translation processes will be required to assure that codes in different ICD standards can be normalized to support existing processes and analysis
- Over 95% of the best possible matches between ICD-9 and ICD-10 codes will be inexact

Business Impacts

There are three primary reasons why the migration to ICD-10 is a "big deal": ICD-10 codes are the foundation for reimbursement and many more business analytics

1. ICD codes are the foundation of health information.
    - ICD-9 or 10 diagnosis codes define the patient's health condition.
    - ICD-9 or 10 procedure codes define the institutional procedures that patients receive to maintain or improve their health.
2. The transition from ICD-9 to ICD-10 represents a major change in the coding system.
    - 14,300 ICD-9 codes to 69,000 ICD-10 codes
    - 3,800 ICD-9 procedure codes to 72,000 ICD-10 procedure codes
    - Major changes in structure of the codes, coding rules and terminology
3. ICD codes are used pervasively through most health care systems.
    - Many business functions are impacted
    - These codes are embedded in financial rules directly or indirectly
    - Many IT systems are impacted
    - Paper and electronic documents are impacted

There is no knowledge as to how these codes will be used and which of the codes will be used for which conditions and procedures, it will be challenging to predict how services and conditions will be reported and paid. Understanding the nature of these codes and assessing the possible effects will be critical to the sustainability of health care organizations

Key areas that are impacted include:

- Clinical documentation improvement
- Coding and coder productivity and accuracy
- Case mix definition
- DRG assignment
- Audits
- Claim denials or adjustments
- Potential preventable readmission and present on admission conditions
- Medical policies and clinical guidelines
- Quality and efficiency assessment
- Fraud, waste, and abuse analysis
- Comparative effectiveness research
- Outcomes measures
- Population health analysis

- Clinical History
- Regulatory Reporting
- Provider/Payer Contracting
- Managing care in an Accountable Care environment.

Who is impacted and how?

Impacted entities would include:

- Providers of all types
- Payers of all types
- Clearinghouses
- Software Vendors
- Third Party Administrators
- Self-Insured Employers
- Suppliers (equipment, paper forms)
- Laboratories
- Members (health riders)
- National organizations (health statistics, etc.)

Internal operational impacts and considerations include:

- Software upgrades needed for in-house applications
- Purchased applications revisions and rolled out to supported sites
- Electronic transactions will need to incorporate the changes
- Procedures will need to be modified
- Paper forms re-design
- Reimbursement schedules review and potentially re-negotiation
- Statistics analysis to prevent distortion or loss of data
- Report analysis
- Treatment policies will need adjustment
- Transitional period
- In addition, diagnostic related groupings (DRG's) are classifications of diagnoses that are used to determine inpatient payment amounts. These groupings are based in part on ICD coding. It is unclear if the DRG structure would require change
- Technical requirements are often underestimated. The reality is that most of the major changes associated with this transition are business changes that will require significant system changes to support the new business requirements. Many of those requirements (e.g. to support Meaningful Use) are yet to be defined and will require significant planning process. The following represents a limited list of some of the technical changes that may be needed to support these new business requirements.

Training – A Critical Element

You'll need to educate almost everyone in your organization and facilitated early enough to develop proficiency without being so far in advance that knowledge is lost. Training should include senior staff as well as middle management, supervisors, line workers and information systems personnel and begin at the provider level, continue through their administrative staff, through clearinghouses and payers, and cross to the consumer (i.e. insurance customer).

- Coders-expanded code sets and anatomy refreshers
- Physicians-required specificity
- Physician office managers- access office workflow
- Staff who assign diagnosis/procedure codes –this is a much broader audience that it may initially appear

- Financial planning and administrative staff – decision support and financial analytics
- Clinical quality and process improvement teams – reporting and use of enhanced coding for reporting
- Payers – eligibility, claims, auditing and reimbursement

What are the benefits?

There are many benefits to adopting the new code sets, listed below are specific examples:

Information

- Greater detail
- Enhanced category models
- Greater severity and risk definition
- Forward flexibility
- Precision definition
- Integration of clinical information

Business

- More precise payment
- Appropriate contracting
- Better definition of risk, severity and case mix
- Improved measures
- Risk prediction
- Fraud and abuse detection
- Network management
- Compliance

What are the costs?

Both health care providers and the organizations that pay for care will have to modify their information systems to accommodate the new codes. Anyone working directly with diagnosis and procedure codes will also require training. Because of the number of systems and people involved, the cost of this transition will be significant.

Several reports have been published estimating the cost of implementing the new codes, there is considerable variation in cost estimates across these studies, most suggest that the cost will be in the billions and require a significant refocusing of existing resources. Based on a review of this literature:

- A preliminary estimate of the total cost to the healthcare system would be $3.2 to $8.3 billion
- The implementation will cost the Medicare program between $200 and $220 million.
- The implementation will cost state Medicaid programs $1 to $3 million each.
- Requiring health care providers and private payers to speed up implementation has the potential to increase costs and result in a less effective implementation.
- Loss of productivity during training and testing phases will last three to six months and there is much discussion on whether productivity will be fully regained based on the complexities required.
- Estimates of the system implementation cost for a 400+ bed hospital range between $500,000 and $2,000,000 per entity.
- Estimates of the cost of implementation for clinical practices range from $83,000 for a small clinical practice to over $2,700,000 for a large clinical practice.

- Due to lack of organizational assessment experience when these estimates were made, the actual cost of implementation across the industry could be substantially higher.

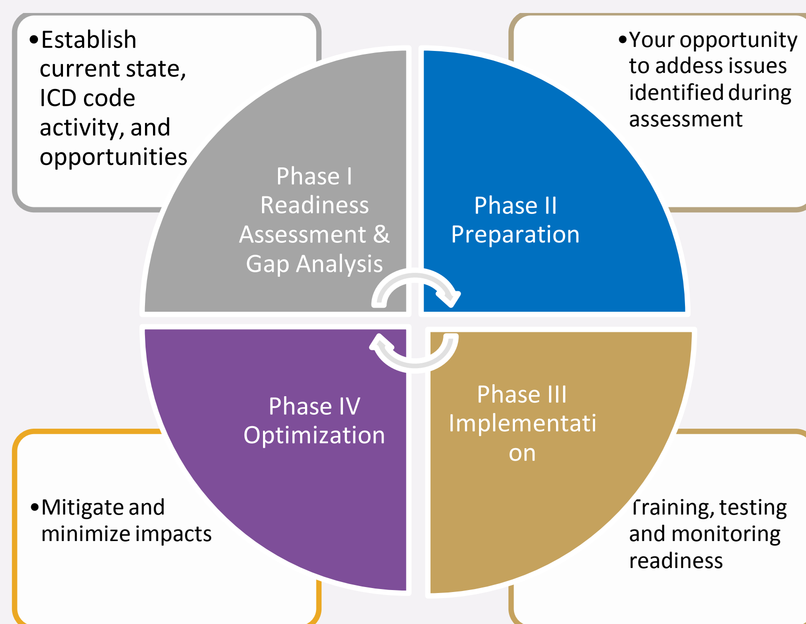
Preparation is Key to Success

Access your organizations readiness for the transition to ICD-10 and develop a plan.

- ***Focus on awareness education now.***
- ***Look at current clinical documentation needs and develop action plans for improvement before ICD-10 implementation.***
- ***Prepare a readiness assessment and GAP analysis for all affected systems and processes then implement action plans for any items identified.***
- ***Complete a comprehensive education plan, virtually everyone in your organization will be impacted.***

Tango*2* ICD-10-CM/PCS Service Offerings

The preparation for ICD-10-CM/PCS is extensive, now is the time for focus to assure successful implementation. Our 4 phase approach builds on the prior one(s) and is designed to move your organization closer to a seamless incorporation of ICD-10 codes into daily routines while maintaining operational control.



We are here to assist you with every step along the way, planning, preparing, implementation and post implementation transition.

How do I begin?

To learn more about ICD-10-CM/PCS and the services Tango*2* offers, please contact:

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