ICD-10 Is Coming
An Update on Medical Diagnosis and Inpatient Procedure Coding

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In October 2014, the United States will switch from using the ICD-9 coding system to ICD-10. This change will allow for greater specificity in describing medical conditions and the addition of new codes as medical knowledge and technology evolve. The change will be a big one for hospitals and clinics. This article describes what physicians need to know about the new system and what the organizations they work for need to consider when preparing for the change.

Since 1979, the United States has been using the ninth revision of the International Classification of Diseases (ICD-9). The ICD is used to classify diseases and other health problems on death certificates, in health records, and for national morbidity and mortality statistics. It is also used to monitor the incidence and prevalence of disease and is essential for resource allocation and reimbursement. ICD-10 was endorsed by the World Health Assembly in May 1990 and came into use in 1994. Most other countries now use ICD-10. The 11th revision will be available in 2015.

The Health Insurance Portability and Accountability Act requires hospitals and health systems to switch from ICD-9 to ICD-10 by October 1, 2014. ICD-10 differs from ICD-9 in that it allows for greater specificity in describing a patient's condition; it also allows for new codes to be added as medical knowledge and technology change. That greater specificity will allow for better quality measurement and better analysis of disease patterns. It also will aid researchers, as it captures the severity of illness, which is currently not possible with ICD-9. In addition, ICD-10 will result in more accurate bills being submitted for reimbursement, theoretically reducing waste in the medical system.

With ICD-10, the number of diagnosis codes (-CM codes) will expand from 14,000 to 68,000 and the number of procedure codes (-PCS codes) will increase from 4,000 to 87,000. No physician will need to learn all of these codes. And many of them will be embedded in the drop-down menus of electronic health record (EHR) systems. All physicians, however, will need to know something about the changes headed their way, as they do affect the way they will need to document patient care.

Physicians and ICD-10
The fundamental point for physicians to understand is that because ICD-10 allows for more specificity, the supporting documentation in the medical record will need to be more specific as well. Physicians will need to note the primary diagnosis as they currently do with ICD-9, but with ICD-10 they also will need to attend to the following new sub-classification criteria: laterality, stages of care, specific diagnosis, specific anatomy, associated/related conditions, cause of injury, additional signs/symptoms/conditions, dominant vs. nondominant side, external cause(s) and/or places of occurrence, cause and effect relationship, and recurrent vs. initial. For example, the documentation for a patient with asthma would need to encompass the specific diagnosis, severity, whether it is intermittent or persistent, the level of exacerbation, cause and effect, the history of tobacco use, and exposure to environmental smoke (even prenatal exposure) (Table). In the case of a neoplasm, the supporting documentation would still need to include notations about site (the ovary) and behavior. It also would need to include information about such details as laterality; whether the malignancy is on the left or right side; whether the malignant neoplasm is of the isthmus uteri, endometrium, myometrium, fundus uteri or overlapping sites of the corpus uteri or whether it is unspecified; the disease stage; and the...
The new codes for procedures allow for more specificity as well. Under ICD-10, documentation for joint replacement would continue to include classification of an injury by specific body part and approach, as was required for ICD-9. But it would also need to address the type of material used (metal, metal on polyethylene, ceramic or ceramic on polyethylene).

Making the Transition
Coding is the key to billing and reimbursement. In some hospitals and clinics, charges are reviewed by a coder before they are submitted. During the initial phase of ICD-10 implementation, coders may not be as available for such checks as they have been in the past because of the increased workload. Yet at the same time, payers may be scrutinizing billing documents more closely to determine coverage.

To ensure that the revenue cycle is not disrupted, clinics and hospitals should be preparing for the transition from ICD-9 to ICD-10. It is critical that the physician’s perspective is considered in planning for this transition. Ideally, there should be a physician champion (or several) on your organization’s ICD-10 steering committee. In addition, a physician representative from each specialty or department needs to be involved in communicating the coming changes to others in their departments.

The ICD-10 steering committee should consider the following issues and how they affect physicians as they prepare for the transition:

TRAINING
The impact of ICD-10 is vast, as it will affect nearly everyone in your medical office: staff from the lab, nurses, coders, those who work at the front desk, clinic managers, and physicians and other clinical staff. It also will affect reporting, prior authorizations, policies and procedures, vendor and payer contracts, and Advance Beneficiary Notices, to name a few. Assessing the level of training needed by each employee will be vital, as the amount of training needed will vary, depending on the person’s position. A coder will need in-depth training. Whereas, a physician may need just-in-time training on how to document and code conditions he or she frequently sees. The physicians on the ICD-10 steering committee can help determine how to train their colleagues most effectively, as they best understand how physicians learn and how to do the training so that it has minimal impact on their work schedules.

THE EHR
Representatives from your organization will need to work closely with your EHR vendor to make sure the system is ready for ICD-10. The EHR is critical, as it will allow you to choose diagnoses from a menu and then track those diagnoses to specific ICD-10 codes. (The appropriate code will either be placed directly into the claim or into a queue for further editing by a coder.)

Your organization may need to upgrade its EHR or switch to an entirely new version of the software. The process of ramping up a new system can be a substantial undertaking, and it will require testing of not only the current version of software but also any new interface. Those involved in testing will need to identify any changes to physicians’ workflow that are the result of ICD-10 and include physicians in the design of new processes.

CLINICAL DOCUMENTATION IMPROVEMENT
Your organization should embed ICD-10 into its clinical documentation improvement (CDI) program. To do that, it will need to take steps to find out where physicians and other providers already deliver great specificity in their documentation and then work to maintain it.

Data analytics can help identify where gaps do and will exist. Those involved in finding out where documentation improvements can be made should take small steps to integrate changes well ahead of the full rollout of ICD-10. They should also focus efforts on specific changes around how diagnoses are classified and whether they match up with those used for billing and history purposes.

If your organization does not already have a CDI program, consider creating one. A CDI program is the best bet for embedding ICD-10 concepts in your physicians’ current practice patterns and workflows as well as those they’ll use long after the rollout is complete.

The Big Picture
Finally, remember to pause every now and then. Know that the switch to ICD-10 will not be a rapid one. Before the full rollout takes place next October, clinical staff should focus on building relationships with coding, technical and administrative support staff who have the skills necessary to meet the many of the challenges associated with this transition. Everyone should think big picture; and leaders should remember to tend to their organization’s culture during a shift as vast as this.

Physicians did not go to medical school to learn how to document; but they should respect that ICD-10 provides them an opportunity to provide more complete clinical information about their patients. Better information is better care. In order to best serve your patients, make sure you or another physician is involved in your
organization’s ICD-10 implementation; don’t leave it to others. Every physician is dealing with this transition—view it as an opportunity.

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LEARN MORE ABOUT ICD-10 BY GOING TO THE FOLLOWING WEBSITES:

The Centers for Disease Control and Prevention (www.cdc.gov/nchs/icd/icd10cm.htm)

The World Health Organization (www.who.int/classifications/icd/en/)


Center for Medicare and Medicaid Services (http://www.cms.gov/Medicare/Coding/ICD10/index.html)

AAPC (www.aapc.com/ICD-10/icd-10-codes.aspx)

AHIMA (www.ahima.org/icd10/)