

DON'T WAIT ANY LONGER.
YOU NEED TO TAKE STEPS NOW
TO MEET THE OCT. 1 DEADLINE.

10 Steps to Preparing Your Office for ICD-10 —NOW

The medical press is filled with warnings about organized medicine's transition from ICD-9 to ICD-10. A quick Internet search for "physicians unprepared for ICD-10" returns more than 180,000 results, including a June 2013 Medical Group Management Association study that found physician practices lagging in readiness for the transition.

If this describes your practice, don't panic. You still have time to prepare, but you must begin now.

ICD-10 is scheduled to go into effect on Oct. 1, 2014, for services provided on or after that date. ICD-10-CM will be used in both the inpatient and outpatient setting for reporting diagnoses. ICD-10-PCS will be used for reporting hospital inpatient procedures. Outpatient procedures will continue to be reported with CPT and HCPCS codes.

According to experts, ICD-9 is being replaced because the terminology and classifications are increasingly inconsistent with current clinical practice. In addition, ICD-9 has run out of space to accommodate new codes that address advances in technology, new diseases, and advances in clinical practice.

ICD-10 offers an expanded code set that better defines certain conditions and increases specificity. Public health agencies and many payers support the adoption of ICD-10 because it provides more accurate and detailed information about the patient's condition to support research, population health, and value-based payment (see "Diagnosis coding: It's not just for claims anymore").

While ICD-9 has about 14,000 diagnosis codes, ICD-10 has about 69,000 codes. As such, ICD-10 will require selecting more specific diagnosis codes and more diagnosis codes for each encounter. Adopting the ICD-10 coding system may be daunting, but it will be doable if you take it one step at a time.

1. Order the ICD-10 book.

This is a step every practice can take today. No excuses. Some practices are reluctant to purchase the book because it is labeled a draft version. However, both the ICD-9 and ICD-10 code sets are frozen, except in cases of new illnesses or diseases, so coders and physicians

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TO MAKE CROSSWALKING EASIER, PHYSICIANS SHOULD GO AHEAD AND START USING MORE SPECIFIC ICD-9 CODES.

should feel confident using the current draft book to learn ICD-10 coding.

Practices should also download the general guidelines (100 pages) from the Centers for Disease Control and Prevention website at http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf. Physicians don't necessarily need to read them, unless they do their own coding, but coders should pay close attention to Sections I(A), I(B), and IV of the Official Guidelines. Reading these guidelines will reassure coders that although ICD-10 is not built on ICD-9, there are similarities in the coding conventions that will be familiar to them.

■ ICD-10 will go into effect on Oct. 1, 2014, for services provided on or after that date.

■ To begin learning the new code set, physicians and coders need access to the ICD-10 manual.

■ Some sections of ICD-10 use a seventh character extender, which can have different meanings.

2. Orient yourself to the new code set.

ICD-10 codes are three to seven characters and start with a letter (e.g., J02.0, streptococ-

cal pharyngitis). Not all sections of ICD-10 use a seventh character extender, but for those that do, the character has different meanings from chapter to chapter. For example, a seventh character extender indicates the Glasgow coma scale, fetus, or trimester in the "Pregnancy, Childbirth, and the Puerperium" chapter, and the seventh character indicates initial encounter, subsequent encounter, or sequelae (late effect) in the "Injury, Poisoning and Certain Other Consequences of External Causes" chapter. ICD-10 also includes characters for designating laterality. For example, in some conditions, there are different codes for the right eye, the left eye, both eyes, or an unspecified eye.

ICD-10 also has rules about sequencing of codes on a claim form. These sequencing instructions are similar to those in ICD-9 but a bit more extensive. For heart failure, ICD-9

notes, "code, if applicable, heart failure due to hypertension first (402.0-402.9 with fifth digit 1, or 404.0 or 404.9 with fifth digit 1 or 3)." In other words, if the patient has chronic heart failure due to hypertension, code hypertensive heart disease 402.0-402.9 in the first position, with the correct fifth digit. In ICD-10, chronic heart failure has a list of "code first" conditions, including heart failure due to hypertension and heart failure due to hypertension with chronic kidney disease.

ICD-10 also includes instructions to "use additional" codes in certain cases, as well as "includes" and "excludes" instructions. You'll want to keep an eye out for these notes.

DIAGNOSIS CODING: IT'S NOT JUST FOR CLAIMS ANYMORE

Historically, physician practices have been paid based on the CPT codes reported, not the complexity or acuity of the patient being treated. For example, a level-three new patient visit for a healthy patient with allergies pays the same as a level-three new patient visit for a chronically ill patient with pneumonia. A documented higher level of history and exam may change the level of service; however, the number of diagnosis codes reported on a claim form or the health status of the patient does not directly affect payment.

As the health care system moves from fee-for-service to value-based payments that reward providers for meeting quality and efficiency measures, the acuity of a practice's patient population will affect year-end payment reconciliation. For example, Medicare's shared savings program uses acuity as one of the factors that determines whether an accountable care organization shares in any monetary savings or is assessed a penalty. Medicare or a third-party payer can get this information from claims data. Thus, it will become increasingly important for family physicians to accurately and completely report diagnosis codes if they currently participate or intend to participate in these programs.

3. Crosswalk ICD-9 codes to ICD-10 codes.

Translation programs, which can be found online or within your electronic health record (EHR), are not meant to result in accurate coding and should not be used for code selection, but they can be a helpful starting point. The translation program takes an ICD-9 code and brings up a list of ICD-10 codes from which the accurate and specific code can be selected. The more specific the ICD-9 code is the more likely that an accurate ICD-10 code can be selected.

If a clinician is using the translation program, he or she will probably know which code to select from the options presented; however, the medical record should support the code selected. If a coder is using the translation program, his or her code selection will depend on increased specificity in the clinical documentation.

4. Start using more specific ICD-9 codes now.

Although ICD-10 does have unspecified codes, payers may not accept them in every case. For example, an unspecified code may be recognized for an office visit, and the claim may be paid. However, for diagnostic services and procedures that have national or local coverage determinations, a more specific code may be

chronic systolic heart failure, results in a one-to-one match, ICD-10 code I50.22, chronic systolic (congestive) heart failure.

If the documentation is not specific enough for a coder to determine an ICD-10 code, this will result in a query to the physician and delayed claim submission.

5. Do a gap analysis.

A gap analysis will help you identify what is missing in your clinical documentation that will be needed to support and select the appropriate ICD-10 code. To do a gap analysis, identify your practice's 50 most commonly used diagnosis codes, and sort them by system (respiratory, cardiac, skin, signs and symptoms without a definitive diagnosis, etc.). Starting with one system, select charts that correspond to the diagnosis codes in your list. Look at the documentation in each medical record, and try to select ICD-10 codes based on the documentation. Make a list of the missing clinical information, and begin physician education on those topics. From the CHF example mentioned previously, you might find that physicians need to clarify in their documentation whether the CHF is acute, chronic, acute on chronic, systolic, diastolic, or combined. Ask physicians to document with specificity for patients seen with CHF.

Another place to start is with national and local coverage determinations. For example,

■ ICD-10 allows for greater specificity, such as designating laterality.

■ The more specific your ICD-9 code is, the easier it will be to crosswalk to an ICD-10 code.

■ A gap analysis will help you determine whether your current documentation is sufficient to support ICD-10 code selection.

A GAP ANALYSIS WILL HELP YOU IDENTIFY WHAT IS MISSING IN YOUR CLINICAL DOCUMENTATION.

needed for the claim to be paid. It is still unclear how payers will process claims with unspecified ICD-10 codes, but it will certainly vary.

To get used to selecting more specific codes, and to make crosswalking from ICD-9 to ICD-10 easier, physicians should start using more specific ICD-9 codes now. For example, ICD-9 code 428.0 is for congestive heart failure (CHF), unspecified; however, there are 15 more specific CHF codes in ICD-9. An attempt to crosswalk 428.0 results in an unspecified ICD-10 code, I50.9, but starting with a specific ICD-9 code such as 428.22,

both CMS and private payers have policies about lesion removal. Review those policies, paying attention to the covered ICD-9 codes and their translations into ICD-10. Doing this may help to prevent denials for services.

6. Educate staff.

With the expanded code set and the increased specificity, it will be important for practices, even small practices, to train at least two staff members in ICD-10. Coders, both certified and uncertified, or staff members that function

THERE IS NO WAY TO PREDICT WHETHER ALL OF YOUR PAYERS WILL BE READY FOR ICD-10.

■ Coding staff will need ICD-10 training in early 2014 that includes coding cases.

■ Physician training should begin with what is learned in the gap analysis because it will address the most common diagnoses.

as billers/coders need to understand ICD-10. Do this in the first quarter of 2014 if possible, but no later than the second quarter. Many consultants recommend that the staff member take an anatomy and physiology course before taking an ICD-10 course, which is sound advice, but there may not be time for that. A course that is 1.5 to 3 days in duration and includes coding cases will work for most family medicine practices. The time has passed for “introduction” and “overview” courses that don’t include coding cases. After the training, the trained staff members need to dedicate time each week to practice their new skills, applying them to coding cases and identifying gaps in the documentation.

Nursing staff may need ICD-10 training related to the services they perform, such as giving injections or immunizations or

performing lab tests. Review the process for providing these services. For diagnostic tests, the physician may have already selected a covered indication by code or by written description. For immunizations, the nurse may need to select the appropriate screening diagnosis that matches the immunization performed. The clinical staff may perform preauthorizations for other screening or diagnostic tests. If the physician has documented the indication in words without selecting the ICD-10 code, the nurse may be responsible for selecting the code. It is important to review workflow processes to identify all staff members who use diagnosis codes now and will need education in ICD-10.

7. Educate physicians.

Start physician education with what is learned in the gap analysis, as this will be most connected to their daily reality and therefore most likely to be productive. List what needs to be included in the clinical documentation to support the diagnosis code selected. Continue with the gap analysis and clinical documentation improvement education, prioritizing your most frequently used codes.

Some consultants have estimated that physicians will need 10 to 20 hours of ICD-10 training, but that seems extreme. Few family physicians can afford to take that much time out of patient care, but one day of training should be a reasonable expectation. (See the resources box.) Physicians should be educated by body or organ system and in short, focused intervals. Schedule the training over the summer, close to the time of implementation. In addition, schedule time for training after Oct. 1, when physicians will have specific questions.

8. Talk with your vendors.

Practice management, clearinghouse, and EHR vendors all need to have libraries in their systems and the most up-to-date versions of the code sets. Ask questions about your ven-

RESOURCES

Courses

Clinical Documentation for ICD-10 Training
(American Health Information Management Association)
<https://ahima.optimizehit.com/domain/home>

ICD-10 Documentation Training for Physicians (AAPC)
<http://www.aapc.com/ICD-10/ICD-10-physician-documentation.aspx?gclid=CKPJh9aAgbsCFaTm7AodensA8Q>

Other materials

ICD-9 to ICD-10 Referential Flash Cards: Top 823 Primary Care Diagnoses (American Academy of Family Physicians)
<https://nf.aafp.org/Shop/fpm-coding-tools/coding-flash-cards>

ICD-10 Provider Resources
(Centers for Medicare & Medicaid Services)
<http://cms.gov/Medicare/Coding/ICD10/ProviderResources.html>

ICD-10 Timeline (AAFP)
http://www.aafp.org/content/dam/AAFP/documents/practice_management/payment/ICD10Timeline.pdf

What You Need to Know for the Upcoming Transition to ICD-10
(American Medical Association)
<http://bit.ly/19TqN3B>

ARTICLES IN FPM's ICD-10 SERIES

You can access the following articles in *FPM's* ICD-10 topic collection: <http://www.aafp.org/fpm/icd10>.

"Getting Ready for ICD-10: How It Will Affect Your Documentation," *FPM*, November/December 2013.

"The Anatomy of an ICD-10 Code," *FPM*, July/August 2012.

"ICD-10: What You Need to Know Now," *FPM*, March/April 2012.

Upcoming articles will address the following topics:

- Signs and symptoms in ICD-10,
- Preventive services in ICD-10,
- Coding common diagnoses in family medicine.

review the code selection and sequencing, at least in these early days. As physicians gain confidence in their systems and in their own coding knowledge, less review will be necessary.

Also during the first week in October, coders or other designated staff should be available to answer coding and documentation questions that physicians may have. Avoid

having physicians send their inquiries via a message and wait for a reply; this will delay claims submission and frustrate the physicians. Someone needs to be available to answer questions in real time.

If the practice is currently using a paper encounter form that lists the most common ICD-9 codes, this will not work well after the transition to ICD-10. This method doesn't work all that well with ICD-9 because space limitations prevent the listing of more specific codes, resulting in the use of too many unspecified codes. With the five-fold increase in diagnosis codes in ICD-10, a diagnosis code cheat sheet would likely be long and unwieldy. Regardless of the specific process used, it is critical that the gap analysis and related education be completed prior to the transition to minimize queries to the physician to clarify documentation, which could result in delayed claims.

You can do this

The transition to ICD-10 will be significant, will impact most areas of a practice, and should not be underestimated, but it is doable. A successful transition requires proper planning. Invest in ICD-10 training for staff members, talk to vendors, and plan on physician education closer to the time of implementation. **FPM**

Send comments to fpmedit@afp.org, or add your comments to the article at <http://www.aafp.org/fpm/2014/0100/p9.html>.

dor's readiness in the spring and summer of 2014. CMS has published a list of suggested questions for vendors (see <http://go.cms.gov/1diTGri>), such as the following:

- Will you install products well before the Oct. 1, 2014, deadline, so I can begin testing them?
- Will I need new hardware to accommodate ICD-10-related software changes?
- Will your product allow for coding in both ICD-9 and ICD-10 to accommodate transactions with dates of service before Oct. 1, 2014, and transactions with dates of service after Oct. 1, 2014?

9. Have cash on hand.

There is no way to predict whether all of your payers will be ready for ICD-10. Even established vendors and clearinghouses may have issues that slow down payment. It will be imperative to have cash on hand or a line of credit for the transition. Many experts are recommending that practices have access to enough cash to cover three to six months of operating costs. Begin saving or setting up a line of credit now.

10. Decide on a "go live" process.

The coding process in the early weeks of October will depend on whether physicians are using an EHR and selecting codes in the EHR or using a paper encounter form and circling or writing diagnosis codes. If the physician is selecting codes in an EHR with the help of a translation program, coders should

■ Ask your vendors when their products will include the new code set and whether a hardware upgrade will be required.

■ It's a good idea to have three to six months of savings or a line of credit in case ICD-10 issues cause payment delays after the rollout.

■ Make sure your physicians and staff understand the coding workflow they should follow, and have someone available to answer ICD-10 questions in real time during the transition.