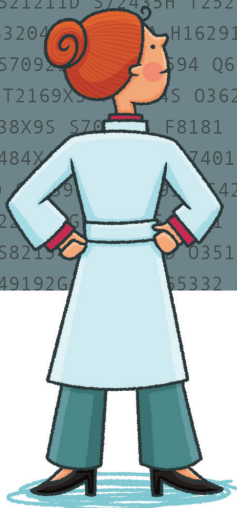


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ICD-10

WHAT YOU NEED TO KNOW NOW



THE GOVERNMENT IS CONSIDERING A DELAY,
BUT THAT DOESN'T MEAN YOU SHOULD.

Cindy Hughes, CPC

Notwithstanding its prior insistence that there would be no delays in the planned transition to ICD-10, the U.S. Department of Health and Human Services (HHS) announced in mid-February that it “will initiate a process to postpone the date by which certain health care entities have to comply.” It’s too soon to be sure, but this suggests that the implementation deadline will be delayed, perhaps by several months, beyond the previous deadline of Oct. 1, 2013. The move by HHS is apparently a response to protests from the house of medicine that the cost and complexity of the transition from ICD-9 make it extremely difficult for practices to make the necessary changes.

While the delay may give you more time to prepare, it most certainly does not mean that you can postpone this work; it just means that if you start now, you might actually be ready by the new deadline. The changes required in your workflow, your technology, and your thinking are massive. And whenever it comes, ICD-10 is coming. It is coming because the inpatient procedure portion of ICD-9 has run out of room for code expansion; because a move from fee-for-service payment to value-based purchasing of health care requires better identification of the complexity of conditions that are treated and managed; and because ICD-10 diagnosis codes convey more detailed information that may reduce delays in claims

processing. Researchers will no doubt gain from the added specificity as well, but this is not the driving force of the transition as some have speculated. Like it or not (and I’d guess not), it seems prudent to take a look at ICD-10 and see what all the fuss is about.

The basics

First, you may already have heard that the move to ICD-10 increases the number of diagnosis codes from about 14,500 to about 69,700. ICD-10 is structured as an incredibly expandable code set using a code structure that begins with an alphabetic character (A-Z except U), which may be followed by any combination of numeric and alphabetic characters. Here are a few examples:

- E11.9: Type II diabetes without complication,
- M1A.071: Idiopathic chronic gout, right ankle and foot,
- I82.4Y1: Acute embolism and thrombosis of unspecified deep veins of right proximal lower extremity,
- S01.01xA: Laceration, without foreign body, of scalp, initial encounter,
- Z00.129: Encounter for routine child health examination without abnormal findings.

As you can see, these codes vary considerably in length, structure, and specificity. This variability requires careful



Article Web Address: <http://www.aafp.org/fpm/2012/0300/p29.html>

**UPCOMING ARTICLES
IN FPM'S ICD-10 SERIES**

The next few articles in our ongoing series will cover the following topics:

- Instructions for using ICD-10 and how the codes are structured,
- Signs and symptoms in ICD-10,
- Coding preventive services with ICD-10.

Watch for them in upcoming issues.

attention to the instructions provided for each three-character category when selecting a code. If you are used to using a quick reference such as the *FPM* "ICD-9 Codes for Family Medicine" short list for selecting codes, this could still work, but not efficiently. In ICD-10, many conditions and injuries are classified according to site, laterality, complication, or other specific characteristics. For example, code S01.01xA includes a placeholder, x, in the sixth position and must include a seventh character – A for initial encounter, S for subsequent encounter, or D for sequela. Omission of the placeholder x or the seventh character will result in an incomplete code and a rejected claim.

ICD-10, with its larger and more complex code set, will require several major adjustments in your practice.

Given the system changes, staff training, and work with vendors required, you will need as much time as possible to prepare for implementation.

Although adopting ICD-10 will require major changes, some discussions of the difficulty have been unnecessarily alarmist.

If you currently assign codes to the services you render, this may be a good time to ask yourself whether your valuable time should be spent on tasks that don't require a medical degree. Physicians are ultimately responsible for codes assigned and billed. True enough. But physicians are also responsible for all patient care, yet they delegate tasks that don't require their judgment and training. Efficient practice in today's environment depends on the right persons shouldering the right responsibilities and working at the top of their knowledge and skill level. Ensuring that professional coding staff receive formal training and that their work is reviewed should reduce compliance risk, administrative burden, and practice costs of the ICD-10 transition. However, this won't relieve all of your responsibility related to ICD-10. Even if you don't select diagnosis codes yourself, don't be surprised if your practice or hospital asks you to increase the specificity of your documentation to support ICD-10 coding. Billing staff cannot assign codes without adequate documentation, and this is especially true for ICD-10.

There is some good news, though. The same National Center for Health Statistics committee that has coordinated maintenance of the ICD-9 diagnosis code set has created and will maintain the ICD-10 diagnosis code

set. This means that changes to ICD-9 codes in recent years have in many cases carried over to ICD-10. You will find that many diagnoses in ICD-10 mirror those of ICD-9, as do the majority of the coding guidelines and conventions for selecting a code. Also, CMS has made available free general-equivalency mapping (GEM) files that can be used by programmers and others to convert codes from ICD-9 to ICD-10 or vice versa. Though conversion is not a one-to-one crosswalk, the GEMs provide a basis for both manual and automated code conversion. The GEMs are also a good tool for checking your manual code selections. Finally, the ICD-10 code set can be used now for training and resource development. CMS has frozen the ICD-9 and ICD-10 diagnosis code sets through Oct. 1, 2014, allowing only changes to correct errors or to add codes for new diseases.

First steps

So what does this all mean to you? ICD-9 codes have been the basis of claims payments and coverage policies for both Medicare and private payers and a means of identifying certain patient populations for quality initiatives. These codes are likely embedded in processes and systems throughout your practice. Your practice should be planning the transition to ICD-10 *now*. Consider these key points:

- Each process or system that uses ICD-9 will need to be identified and converted.
- You need to be familiar with ICD-10 code structure, guidelines, and conventions before you can recognize what must be changed and how.
- Staff who assign diagnosis codes or are directly responsible for billing and claims fol-

About the Author

Cindy Hughes is a coding and compliance consultant with Medical Revenue Solutions, Oak Grove, Mo., and a contributing editor to *Family Practice Management*. Until recently, she was on the staff of the American Academy of Family Physicians. Author disclosure: no relevant financial affiliations disclosed.

low-up will need extensive training as the transition date approaches. Training is available through many sources and in many forms ranging from in-house training to boot camps to online courses. Staff who receive formal training and are well prepared can save your practice from losses in revenue and productivity.

- You will likely need upgrades or new electronic systems to support coding and billing in ICD-10. This is true for every business that deals with health information, so you'll need to get your vendor's attention early.

There is a single transition date for ICD-10 based on the date of service. Claims with a date of service of the transition date and later should include ICD-10 codes. Claims with a date of service prior to that should include ICD-9 codes even if they are submitted after the transition date. This should not create electronic billing system difficulties, since systems are typically developed to allow reporting of ICD-9 and CPT codes that may become invalid after a certain date while also allowing for reporting of new codes on claims with newer dates of service. Ask your vendor for details of how your system will function if you have any concerns about being able to submit claims containing either code set after the transition date.

If you plan to adopt an EHR or replace a practice management system, you will want to know the vendor's plans for implementing and supporting the transition to ICD-10. It's a good idea to ask whether potential EHR products include an analytic decision tree that allows

selection of diagnoses based on each characteristic in the ICD-10 code set – including site, laterality, complication, and others appropriate to the codes.

If you won't have an EHR that helps you assign ICD-10 codes, you may want to review other electronic applications for looking up the codes. For example, a variety of applications already exist for iPad, iPhone, and Android devices; you can find them by searching Apple's App Store or Google's Android Market for *ICD-10-CM* (be careful to not select other versions of ICD-10 that may differ significantly from the U.S. clinical modification).

Whatever the transition date turns out to be, it's probably closer than it might seem. Now is the time to plan and perhaps even budget for the necessary changes. You will find a continuing series of articles on ICD-10 in *FPM* at least until the transition date (subjects of the next few are listed in the box on the previous page). You can also find more information, a sample implementation plan, and training modules online at <http://www.aafp.org/online/en/home/practicemgt/codingresources/icd10cm.html>. We hope to be helpful to you in the transition. **FPM**

Send comments to fpmedit@aafp.org.

1. Nachimson Advisors. The impact of implementing ICD-10 on physician practices and clinical laboratories. <http://nachimsonadvisors.com/Documents/ICD-10%20Impacts%20on%20Providers.pdf>. Published October 2008. Accessed Jan. 27, 2012.

CUTTING THROUGH THE HYPE

While the transition to ICD-10 is a big change and will cost the entire health care system and taxpayers a lot of money, discussions of the change have sometimes been alarmist enough to cause considerable unnecessary anxiety. Here is some food for thought about ICD-10:

- The U.S. version of ICD-10 is made up of two code sets: ICD-10-PCS, which contains about 71,918 codes used only for inpatient procedure reporting, and ICD-10-CM, which contains about 69,700 diagnosis codes reportable for supplies and services in any health care setting. It is likely that even family physicians will use only a small portion of the ICD-10-CM code set.
- Much of the expansion in the number of codes is due to the addition of laterality where applicable. Adding codes to indicate right, left, bilateral, and unspecified laterality greatly increases the number of codes but doesn't unduly complicate code selection.
- ICD-10-CM is not created by a committee of bureaucrats, statisticians, and researchers, though they may participate in the ICD-10 Coordination and Maintenance Committee meetings as do many physician-specialty representatives. Many changes from ICD-9 are requested by physicians to reflect changes in terminology and specification of disease status. For example, ICD-10 diagnosis codes for asthma reflect current guidelines for diagnosing and managing asthma, including whether the condition is mild intermittent, mild persistent, moderate persistent, or severe persistent.
- Some speakers on this topic have reported that it will cost small practices with an EHR approximately \$83,000 to implement ICD-10. The estimate comes from a 2008 study performed by Nachimson Advisors for the Medical Group Management Association and multiple medical-specialty organizations.¹ While a practice may choose to invest \$83,000 or more in the transition to ICD-10, it is unlikely. Will your practice spend \$2,985 to update a superbill? Will it cost you \$44,000 to document characteristics such as laterality, trimester of pregnancy, and whether a patient encounter related to an injury is the first or subsequent encounter with you regarding the injury? Those are a couple of the estimates that contribute to the report's overall estimate of \$83,000 for a small practice. Physician practices should undertake their own assessment and planning to determine the costs of the transition and budget appropriately.