Preparing for ICD-10:
How the ICD-10 Transition Can Affect Your Practice Operations

Learning Objectives:
• Understand the current ICD-10 regulatory environment
• Clearly define the ICD-10 transition
• Compare ICD-9 vs. ICD-10 coding
• Learn how ICD-10 can affect your practice operations
• Explore guidelines for creating an action plan
• How to avoid risky coding practices

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- Regulatory Environment -
• In January of 2009 the Department of Health and Human Services released the final rule adopting the use of ICD-10 as the new standard for diagnosis and inpatient procedure coding. The original compliance date was October 1st, 2013.
• That rule was delayed by one year in both March 2012 and April 2013.
• The current national transition date is October 1st, 2015.
• Will another delay occur? No way to be sure, however:
  ✓ 3 bills exist in Congress to alter the ICD-10 implementation – none are scheduled for a vote as of 6/19/2015.
  ✓ The Congressional representative that inserted the delay language last year has unequivocally stated that his committee supports no delay for the 2015 deadline.
  ✓ The legislation that delayed ICD-10 last year passed both the House and Senate with no delay provisions in April 2015.
Preparing for ICD-10

- What exactly is the ICD-10 transition? -

• All HIPAA covered entities, including providers (of all sizes), claim intermediaries (clearinghouses) and payers will transition from the current diagnosis and inpatient procedure coding system (ICD-9) to the new standard (ICD-10).
• This transition affects ICD codes only – it does not affect CPT®, Revenue or HCPCS codes as they are not part of the International Classification of Diseases.
• This transition is big bang – no early or phased adoption for production claim processing/adjudication is allowed even if your practice is fully prepared to utilize the new code set.
• ICD-9-CM Volumes I & II (Diagnoses) transition to ICD-10-CM
  ✓ Used on professional and facility claims
• ICD-9-CM Volume III (Inpatient Procedures) transitions to ICD-10-PCS
  ✓ Used on facility claims only

- Why is the United States making this change? -

• The structure and format of ICD-9 dates back to the late 1970s.
• Both CMS and the CDC have stated that we are running out of numbers to assign new diseases making the code set more obsolete.
• The large majority of the developed world have already moved to ICD-10 for diagnosis coding. The United States is one of the last countries to make this transition.
• Comparing healthcare data with the majority of the world is difficult under the ICD-9 system.
• The Government is looking to use detailed administrative data (coding data) to measure the efficacy of treatments and decrease what it deems waste, fraud or abuse in the American healthcare system.
• ICD-9 lacks specificity characteristics necessary for more detailed medical research and financial analysis.
Comparing ICD-9 with ICD-10

- **ICD-9-CM Volumes I & II**
  - ~14,000 codes
  - Starts with a number, E or V
  - Largely numeric
  - No laterality (R, L, BIL)
  - No episode of care
  - E codes refer to external causes of injury/morbidity
  - V codes refer to factors influencing health status

- **ICD-10-CM**
  - ~69,000 codes
  - Starts with a letter - always
  - 7 digit maximum
  - Laterality for almost any anatomic structure where two exist
  - Injury/trauma sections require an initial, subsequent or sequela (late effect) episode of care
  - V, W, X & Y codes refer to external causes of injury/morbidity
  - Z codes refer to factors influencing health status

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**Medical Example**

**ICD-9 Diagnosis**

381.01  Acute serous otitis media

**ICD-10 Translation**

H65.00  Acute serous otitis media, unspecified ear
H65.01  Acute serous otitis media, right ear
H65.02  Acute serous otitis media, left ear
H65.03  Acute serous otitis media, bilateral
H65.04  Acute serous otitis media, recurrent, right ear
H65.05  Acute serous otitis media, recurrent, left ear
H65.06  Acute serous otitis media, recurrent, bilateral
H65.07  Acute serous otitis media, recurrent, unspecified ear

Note that the translation is 1:many and includes laterality and persistence (FYI - recurrent is not chronic).
### Behavioral Health Example

<table>
<thead>
<tr>
<th>ICD-9 Diagnoses</th>
<th>ICD-10 Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>314.00 Attention deficit disorder without mention of hyperactivity</td>
<td>F90.0 Attention-deficit hyperactivity disorder, predominantly inattentive type</td>
</tr>
<tr>
<td>314.01 Attention deficit disorder with hyperactivity</td>
<td>F90.1 Attention-deficit hyperactivity disorder, predominantly hyperactive type</td>
</tr>
<tr>
<td></td>
<td>F90.2 Attention-deficit hyperactivity disorder, combined type</td>
</tr>
<tr>
<td></td>
<td>F90.8 Attention-deficit hyperactivity disorder, other type</td>
</tr>
<tr>
<td></td>
<td>F90.9 Attention-deficit hyperactivity disorder, unspecified type</td>
</tr>
</tbody>
</table>

Note that the translations include characteristics not available in ICD-9.

### Injury/Trauma Example

<table>
<thead>
<tr>
<th>ICD-9 Diagnosis</th>
<th>ICD-10 Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>947.0 Burn of mouth and pharynx</td>
<td>T28.0XXA Burn of mouth and pharynx, initial encounter</td>
</tr>
<tr>
<td></td>
<td>T28.0XXD Burn of mouth and pharynx, subsequent encounter</td>
</tr>
<tr>
<td></td>
<td>T28.0XXX Burn of mouth and pharynx, sequela</td>
</tr>
</tbody>
</table>

Note that the translation is 1:many, extends to 7 digits and includes episode of care.
- Former V Code Example -

<table>
<thead>
<tr>
<th>ICD-9 Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>V06.1 Need for prophylactic vaccination and inoculation against diphtheria-</td>
</tr>
<tr>
<td>tetanus-pertussis, combined [DTP] [DTaP]</td>
</tr>
<tr>
<td>V06.2 Need for prophylactic vaccination and inoculation against diptheria-</td>
</tr>
<tr>
<td>tetanus- pertussis with typhoid-paratyphoid (DTP + TAB)</td>
</tr>
<tr>
<td>V06.3 Need for prophylactic vaccination and inoculation against diptheria-</td>
</tr>
<tr>
<td>tetanus- pertussis with poliomyelitis [DTP + polio]</td>
</tr>
<tr>
<td>V06.4 Need for prophylactic vaccination and inoculation against measles-</td>
</tr>
<tr>
<td>mumps-rubella (MMR)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10 Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z23 Encounter for immunization</td>
</tr>
</tbody>
</table>

Note that all of these V code immunizations translate to the same Z code and specificity was removed.

- How does this change affect your practice? -

1. Information Technology. Systems like your practice management software and electronic health record will require testing and a transition plan to handle ICD-10 codes.

2. Clinical Documentation. ICD-10 requires more characteristics to get to a terminal level of code specificity. A lack of this specificity can result in the higher use of unspecified codes.

3. Coding and Abstraction. Coders will need a greater knowledge of both anatomy/physiology and disease processes.

4. Paper Billing Processes. The superbill / charge ticket / encounter form as it exists today will need to change drastically to accommodate the number of codes available.

5. Claim Acceptance and Adjudication. Less specificity can mean higher denial rates. Simultaneous payer transitions are difficult.

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What should your practice be doing to prepare? (1/3)

1. Information Technology
   - Work with your technology vendors and support personnel to assure that your systems can handle ICD-10 codes.
   - Understand any new workflows inside those applications that change as a result of the transition.
   - Test that new functionality – both the usage of ICD-10 inside the system and its ability to generate electronic and paper claims.
   - Touch base with clearinghouses and trading partners to understand their transition process.

2. Clinical Documentation
   - Understand the specificity for your most commonly used diagnoses and begin adopting documentation standards that support coding to the highest level of specificity.
   - This applies to E&M, Office Procedures, OR Procedures, Inpatient and Outpatient encounters.

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What should your practice be doing to prepare? (2/3)

3. Coding and Abstraction
   - Train coders on the abstraction and application of the new codes including the new coding guidelines issued by CMS.
   - Take advantage of industry trade groups and specialty medical associations that offer coding guidance and education.
   - Educate all staff (including front desk and billing) about the characteristics of ICD-10.
   - Practice coding real cases in ICD-10.

4. Paper Billing Processes
   - If you are using paper billing forms, the diagnosis sections of the superbill / charge ticket / encounter form should be translated to ICD-10. This often requires a specialized skillset.
   - You may find that the diagnosis section becomes so large that it functions better as a static reference sheet rather than a part of the form to be submitted for billing.
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5. Claim Acceptance and Adjudication

- Payer transitions are notoriously difficult and riddled with a lack of communication.
- Research your top 10 payer ICD-10 portals for up to date information on their transition plan.
- Pay specific attention to:
  - Pre-cert requirements for procedures after 10/1/2015
  - Issuing insurance referrals in systems like Navinet®
  - Medical policy acceptable code ranges translated to ICD-10

6. Collections

- Expect strange claim rejections and denials to increase as payers transition to the new code set.
- Plan for the cash flow of the practice to be interrupted during this transition and make other financial arrangements as necessary.

- ICD-10 Coding Practices to Avoid -

- Using unspecified laterality codes when laterality is known
  - Example: H65.00 - Acute serous otitis media, unspecified ear.
  - Using this code means the billing provider did not know which side/ear was infected, despite the probable treatment of that side.
  - Using these codes in scripts, referrals or pre-certs is discouraged.
  - Using these codes in claims may result in denials.

- Laterality conflicts between CPT modifier vs. ICD-10 diagnosis code
  - Some CPT codes allow for a –RT / -LT / -59 (laterality) modifier.
  - It is now possible for diagnosis laterality to conflict with the CPT modifier laterality.
  - Example: Billing a diagnosis code that includes “right lower leg” but putting an “–LT” on the procedure code.
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- **Summary** -

- **October 1, 2015** is the most recent national transition date.
  - Transition is simultaneous for providers, intermediaries and payers.
- Diagnosis code format, volume and specificity are drastically different.
- Remediate and test practice management and EHR software.
- Enhance clinical documentation to support your high volume codes.
- Train coders on the new rules for applying ICD-10 and practice coding with real cases.
- Translate paper diagnosis forms.
- Research and understand the ICD-10 guidelines for your top payers and trading partners/clearinghouses.
- Financially prepare for higher rejection and denial rates during the transition.
- Avoid financially risky ICD-10 code usage and transactions.

- **What's next?** -

- **Future webinars will focus on:**
  - July 14th, 2015
    - 7:00am | 12:00pm | 7:00pm
    - ICD-10 Testing:
      - Testing Your EHR, Practice Management System and Internal Processes for ICD-10 Readiness
  - September 2nd, 2015
    - 7:00am | 12:00pm | 7:00pm
    - Final Preparations for the National Transition Date