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Frequently asked questions: ICD-10

To help health care providers and payers prepare for ICD-10, Optum has prepared the following answers to frequently asked questions.

ICD-10 Regulations

Q: What is the ICD-10 implementation deadline?

A: The Department of Health and Human Services (HHS) has mandated that all covered entities (health plans, health care clearinghouses, and certain health providers) that bill Medicare for services must begin using the ICD-10 code set on Oct. 1, 2014. There are two ICD-10 code sets: the International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM), and the International Classification of Diseases, 10th Edition, Procedural Classification System (ICD-10-PCS).

The Oct. 1, 2014, deadline is an extension of HHS' original implementation deadline of Oct. 1, 2013. The extension was granted based on the urging of stakeholders throughout the industry that expressed serious concerns about their ability to meet the Oct. 1, 2013, compliance deadline, and research that detailed the industry's progress toward meeting the deadline. One survey reported that approximately 50 percent of providers did not know when they would complete their impact assessment of the ICD-10 transition, according to a February 2012 survey conducted by the Workgroup for Electronic Data Interchange (WEDI).

Q: Will ICD-10-PCS replace CPT® codes?

A: ICD-10-CM will replace ICD-9-CM for diagnosis coding. ICD-10-PCS will replace ICD-9-CM Volume 3 for inpatient procedure coding. HHS has stated that Current Procedural Terminology (CPT®) will remain the coding standard for physician services.

Q: Will there be a grace period for submitting ICD-9 claims after the deadline?

A: The Centers for Medicare & Medicaid Services (CMS) has stated that it will not accept claims using ICD-9 for discharges on or after Oct. 1, 2014. From that date forward, only claims encoded using the ICD-10 code set will be accepted. Commercial payers and state Medicaid plans are also requiring providers to begin using the ICD-10 code set on Oct. 1, 2014.

About ICD-10

Q: What are some of the differences between ICD-9 and ICD-10?

A: ICD-10 is substantially more complex than ICD-9, making it difficult for coders to solely rely on their ability to recall or manually look up codes when doing their jobs. There are approximately 155,000 ICD-10 diagnosis and procedure codes, versus only about 24,000 ICD-9 codes. Many of the additional codes in ICD-10

represent laterality (e.g., right side, versus left side), while others are more precise codes to represent specific anatomy and physiology. As a result, coding a diagnosis in ICD-10 is likely to require more codes to accurately represent the condition. For example, coding an ankle sprain in ICD-9 requires only four codes, while it may require up to 72 codes when using ICD-10.

There are many similarities between ICD-9-CM and ICD-10-CM, such as the coding conventions that are used. The chapters in ICD-10-CM, however, are better organized than they were in ICD-9-CM. For example, neoplasms, which were previously scattered throughout ICD-9-CM codes, are now contained within the same chapter, and all neoplasm codes start with the letter C (think of "C" as in cancer, to remember neoplasm codes). Likewise, codes for obstetrics all start with the letter O, and diabetes mellitus codes start with the letter E (think of "E" as endocrine).

Q: What are ICD-10 mapping tools?

A: Mapping tools are used to translate ICD-9-CM codes into ICD-10-CM or PCS codes (a process called forward mapping), and to translate ICD-10-CM or PCS codes back into the ICD-9-CM format (called backward mapping). Since the two classification systems are so different, both forward and backward mapping might result in several valid code alternatives from which appropriate code selection(s) must be made. There is no simple "crosswalk." Also, it is important to point out that mapping is a tool and not a substitute for learning the ICD-10-CM and PCS code sets, as relying on mapping tools to code encounters would be far too time consuming.

CMS does provide a General Equivalence Mapping (GEM) data file that can be downloaded from its website. However, the mapping data is presented in a very basic raw data. Optum provides several products, from printed resources to software, that simplify the information for the user. Go to www.optumcoding.com to learn more about the mapping resources available from Optum.

Optum's ICD-10 Preparations

Q: How is Optum preparing for the ICD-10 transition?

Investments — Optum has invested more than $10 million in preparation for ICD-10 and related technology migrations.

Solution upgrades — Optum is currently evaluating all solutions and services that will be impacted by the ICD-10 transition. Many solutions and services — including computer-assisted coding (CAC), encoding solutions, and referential products — are already ICD-10 compliant. Remaining solutions and services that require upgrades or modifications to become compliant will be announced in the coming months. Detailed project plans and schedules are being developed now. All currently supported solutions and services will be ICD-10 compliant well before the Oct. 1, 2014, deadline. Details about upgrades, modifications, and migration plans will be announced in the coming months.

Testing — Optum will test its solutions and services for ICD-10 compliance well before the Oct. 1, 2014, deadline, and provide its customers with methods to test their existing solutions for compliance. Details will be announced in the coming months.

Coding books, resources and referential materials —- As one of the industry's leading providers of coding resources, Optum currently offers a wide array of books, resources, and referential materials that are specifically devoted to ICD-10. Find details about these products at www.optumcoding.com.

CAC solutions — Optum Computer-Assisted Coding Professional can help organizations streamline ICD-10 preparation and implementation. Because CAC automates much of the work, it can help mitigate the expected productivity drops during conversion.

Q: Will Optum's clearinghouses support the dual use of ICD-9 and ICD-10 codes?

A: Optum has the capability of accepting claims with ICD-9 codes and claims with ICD-10 codes. It will also have the capability to send ICD-9 or ICD-10 claims to the respective payers, based on the payer's requirements. During the ICD-10 testing phase, Optum will be supporting both ICD-9 and ICD-10. The ICD-10 ruling states that the adoption of ICD-10 must be completed by Oct. 1, 2014, and Optum will be prepared for this date as well as any Industry shifts that may occur between now and the mandated date. Optum will be prepared to handle both ICD-9 and ICD-10 during the transitional adoption period as defined by CMS.

ICD-10 Considerations

Q: Will organizations continue using ICD-9 after the Oct. 1, 2014, deadline?

A: Although Medicare, Medicaid, and commercial payers will require providers to submit claims in the ICD-10 format as of Oct. 1, 2014, both providers and payers will still have a need to use ICD-9 after the deadline, such as in the following situations:

Historical Claims Analysis — Coding professionals — as well as payer claims analysts — will need to use mapping tools to translate ICD-9-CM and ICD-10-CM and PCS codes to make meaningful comparisons between diagnoses, procedures, reimbursement, and other issues that took place before and after the October deadline. These analyses may also include the evaluation of claims for case management, outcomes, utilization trends, and population health.

Identifying High-Risk Codes — Today's trend analytics are based on ICD-9-CM codes and will need to be translated into ICD-10-CM and PCS codes. The translation process can be challenging, since a single ICD-9-CM code might correspond to several ICD-10-CM

or PCS codes. HIM departments will need to work with medical management and disease management to determine the applicable codes, or greatly expand on the codes that trigger alerts.

Provider/Payer Contracting — Currently, provider contracts with payers are structured using ICD-9-CM codes. These contracts will require renegotiation using ICD-10-CM and PCS codes after the October 2014 deadline, and possibly before the deadline in cases where the contract expires before October. Providers will likely need to enlist the expertise of outside consultants to help assess and navigate contract negotiations and payer management. Coding professionals will need to work with other departments within their organizations to assess contract changes based on the differences between ICD-9-CM and ICD-10-CM and PCS. Particularly important is the analysis of new value-based purchasing or incentive-based contracts that place provider reimbursement as risk depending upon the achievement of patient outcomes and other quality measurements. Accurate code mapping between ICD-9-CM and ICD-10-CM and PCS will help providers negotiate fair contract terms.

Q: What will be the financial impact of ICD-10?

A: Physicians, facilities and payer organizations are concerned with the impact of reimbursement changes under ICD-10-CM and PCS. In many cases, a patient encounter will earn a different reimbursement amount when it is coded in ICD-9-CM, versus coding the same encounter using ICD-10-CM or PCS. Many physicians, facilities, and payers are currently researching if the differences will even out over time, or achieve what the industry is calling a "financial neutrality" (more reimbursement earned for some encounters that compensates for the lower reimbursement received for other encounters).

Once sufficient ICD-10-CM and PCS claims history is collected, HIM departments may be asked to analyze ICD-9-CM and ICD-10-CM and PCS claims to determine shifts in coding and reimbursement trends that impact provider finances. Findings from the analyses may result in changes to coding policies, claim editing, and provider documentation education.

Preparing for ICD-10

Q: How can organizations budget for lost productivity during the ICD-10 transition?

A: All organizations need to make preparations for the training of coders, claims analysis staff, and any other employees having claim-based roles. HHS estimates total training costs for full-time hospital coders at $2,750 per coder ($2,200 for lost work time, plus $550 for training expenses), and $550 for part-time coders ($440 for lost work time, plus $110 for training expenses).

In addition, providers should plan for the use of outsourced coding services. During the peak of the transition, coding services can help facilities manage the increased workload, as well as maintain efficiency and cash flow.

Q: How should organizations assess the impact of ICD-10?

A: The American Health Information Management Association (AHIMA) has published a list containing many of the systems that will be affected by the ICD-10 transition. The list includes the following systems that are used at physician practices, hospitals, payers, and clearinghouses. Organizations need to evaluate the systems listed below to determine if they are ready for ICD-10, or if collaboration with vendors will be required to modify or upgrade the systems and services, which include:

- Accounting systems
- Aggregate data reporting
- Billing systems
- Case management
- Case-mix systems
- Clearinghouse EDI systems
- Clinical protocols
- Clinical reminder systems
- Clinical systems
- Decision-support systems
- Disease management systems
- Encoding software
- Medical necessity software
- Medical record abstracting
- Payer claims adjudication systems
- Performance-measurement systems
- Physician practice management systems
- Provider profiling systems
- Quality management
- Registration and scheduling systems
- Test-ordering systems
- Utilization management

Q: How can organizations use ICD-10 mapping to start the training process?

A: There are several opportunities for coding professionals to use mapping tools in advance of the ICD-10-CM and PCS implementation deadline. These include using mapping tools to help coders learn ICD-10-CM and PCS coding concepts and classification changes, as well as to understand the contrast and similarities among to the two code sets. Other uses for mapping tools include:

- Analyzing the most frequently used ICD-9-CM codes to predict how reimbursement will be impacted upon the switch to ICD-10-CM and PCS
- Identifying high-priority coding issues to help train coders for the transition
- Updating coding and billing tools to ICD-10-CM and PCS, such as super bills, forms, reports, etc.
- Selecting new technology solutions that will help organizations transition to ICD-10-CM and PCS
- Validating the logic and code selection in coding tools

Q: Should coders increase their knowledge of anatomy and physiology to use ICD-10?

A: The greater specificity of ICD-10-CM and PCS, along with the inclusion of laterality, will require coders to increase their knowledge of anatomy and physiology. The general diagnosis codes in ICD-9-CM are replaced in ICD-10-CM with codes that indicate the side of the body, and quite often the specific body part involved in the diagnosis. As a result, coders will need to familiarize themselves with a greater number of anatomical and physiological terms to code properly.

Early in the initial training process, organizations should assess the knowledge levels of coders in the areas of anatomy and pathology. Conducting this early in the process will enable organizations to determine areas where additional training is needed, and allow enough time for thorough training. Educational sessions should include hands-on use of the ICD-10-CM and PCS code sets so coders can see precisely where their increased knowledge will be applied in day-to-day coding work.

Q: When should organizations start their formal ICD-10 training?

A: Intensive ICD-10-CM and PCS training — including book-based code selection and training on encoder usage — needs to take place six to nine months before the ICD-10 deadline so that the information will be retained once live ICD-10-CM and PCS coding is initiated. At this stage, fundamental training (e.g., ICD-10-CM and PCS structure, additional anatomy and pathology education) should be completed through online and/or in-person education programs.

Q: Where should clinical documentation improvement (CDI) programs focus?

A: The greater specificity of ICD-10-CM requires clinical documentation to include a higher level of detail that is often absent in today's documentation. These details include laterality, the causal factors of a condition, the current state of the condition, underlying conditions, and more. The absence of these specifics within clinical documentation can prevent organizations from earning all the reimbursement that is allowed for patient encounters.

To prepare for the ICD-10 transition, coders and CDI specialists need to familiarize themselves with the differences between ICD-9-CM and ICD-10-CM so they will be aware of the changes needed to improve documentation practices. Additionally, provider organizations will need to focus the clinical documentation improvement efforts on those areas most likely to cause coding errors and significantly impact revenue.

A recent study suggests that the industry's current documentation practices may lack the details needed to leverage the specificity of ICD-10-CM. The American Health Information Management Association (AHIMA) published findings in the winter of 2012 about a pilot study using ICD-10-CM to code existing clinical documentation.[1] Within the pilot study, two coders trained in ICD-10-CM coded a total of 491 de-identified records from two sources. Following the coding of the records, random samples were selected and reviewed for coding accuracy. Excerpts from the findings show that:

- 86 percent of "records with heart disease as a principal or secondary diagnosis had an unspecified ICD-10-CM heart disease assigned," since the specific type of heart disease was absent in the clinical documentation.

1. J Moczygemba, S Fenton. "Lessons Learned from an ICD-10-CM Clinical Documentation Pilot Study." http://perspectives.ahima.org/index.php?option=com_content&view=article&id=232:lessons-learned-from-an-icd-10-cm-clinical-documentation-pilot-study&catid=45:icd-9icd-10&Itemid=93.

- Coding for pneumonia cases resulted in frequent use of unspecified organism codes, since the clinical documentation did not state the causal organism.
- Particularly generic codes were assigned — due to lack of documentation — in some cases, such as K82.9 (Disease of gallbladder, unspecified) and N19 (unspecified kidney failure).

Q: How will ICD-10 impact medical necessity justification?

A: Assigning the proper diagnosis codes to comply with medical necessity requirements is largely dependent on having proper clinical documentation. Increased details within documentation will enable coders to obtain the maximum reimbursement for all the care that was delivered — while complying with medical necessity requirements. The greater specificity of ICD-10-CM will drive improvements in clinical documentation, prompting coders to work with clinicians to clearly record:

- The impact of complications and comorbidities
- Why diagnostic tests were ordered
- The severity of the patient's condition

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