ICD-10 is around the corner—are you ready?

by Anny Pang Yuen, RHIA, CCS, CCDS

Did you know the United States is the last country in the world to adopt ICD-10? Many organizations held off on preparations, waiting in case another delay came. Now, however, the clock continues to tick, louder and louder. Now, the reality of ICD-10 looms—for many, it looms large. Implementation is less than 30 days away.

According to CMS, we must transition to ICD-10 because:

- “ICD-9 has outdated terms, and is inconsistent with current medical practice.”
- “ICD-9 produces limited data about patients’ medical conditions and hospital inpatient procedures.”
- “The structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full.”

Systems check

If you’re not on top of your ICD-10 implementation initiatives, you may be scrambling to make sure your systems are in place to accept the code changes, along with making sure everyone in your organization is properly trained.

Many working in the healthcare industry witnessed the holdup in billing, specifically the Discharged Not Final Billed, known as the DNFB report, during the transition to MS-DRGs back in 2007.

So those with foresight may be anticipating that the ICD-10 transition could be an even bigger issue for the revenue cycle. If payers and/or hospital billing systems are not able to submit and/or accept the claims using ICD-10 codes on October 1, 2015, those claims won’t be reimbursed.

Hopefully, however, with the many delays of ICD-10, organizations have taken advantage of the time and done their due diligence, assessed their current workflows, and successfully performed a remediation of systems and templates.

Additionally, facilities should have already provided the necessary training to all the different types of professionals who need to understand the importance of the transition.
Workflow adjustment

As an industry, we recognize that documentation specificity will be significantly increased in ICD-10, but how can an organization work smarter instead of harder during this transition?

Many organizations have either implemented CDI programs or employed their CDI teams to assist with the transition. The goal is to have the CDI team clarify any documentation gaps and/or ambiguities before the medical record gets to the coding team. The collaboration of CDI and coding can really help minimize retrospective ICD-10 coding queries and improve overall coding productivity in a time when most industry experts expect productivity lags of 20%–30%.

Additionally, it is really important for organizations to determine who will be involved in provider education and to address potential workflow issues prior to October 1 to ensure the transition from ICD-9 to ICD-10 is as smooth as possible.

Luckily, the mechanics of ICD-10-CM (diagnosis coding) are actually very similar to ICD-9. Therefore, the biggest learning curve for most will be in procedure (PCS) coding. ICD-10-PCS is a completely new coding system with its own guidelines, so documentation requirements will be different. Traditionally, CDI specialists have not queried physicians regarding the assignment of procedure codes unless it was related to type of debridement since such codes typically did not add a CC/MCC. Yet the additional specificity coupled with concerns regarding coder productivity may make it feasible for CDI specialists to own both the CM and PCS query processes.

This means that, if your organization has not examined this area, it will need to determine who will query providers regarding the assignment of PCS codes, review the specificity requirements for non–operating room procedures, and examine current templates for “simple” procedures to include the level of specificity needed in ICD-10.

For example, transfusions and venipuncture will require further specificity in ICD-10, but this level of specificity may be captured within a template procedure note rather than having a query placed for each occurrence.

Refocused CDI efforts

We can all hope for the best outcomes after October 1, but for now, during this transition period, CDI specialists should consider the following items during their current reviews and begin incorporating them into their provider queries:

- **Laterality:** Much of the increase in ICD-10 codes is due to the capture of laterality; therefore, CDI specialists can begin educating providers on the importance of documenting laterality.

- **Acuity and chronicity:** This documentation was important in ICD-9, and it remains so in ICD-10. Providers should always document the acuity or chronicity of all diagnoses. Physicians need to explain whether a condition is a new onset (acute) or whether the patient has been experiencing the condition for a period of time and/or for more than three months (chronic). The documentation of acuity helps support the level of care given to the patient.

- **Linkage of conditions:** In ICD-10, documentation must often support a relationship between two conditions in order for a combination code to be assigned. Therefore, it is important for providers to document a cause-and-effect relationship between related conditions. For example, the provider must document a cause-and-effect relationship between hypertension and heart failure/heart disease.

- **Procedure coding:** One must know the body system and/or body part, objective of procedure, approach and/or technique, and device to properly assign a PCS code. If that information isn’t in the chart, then someone—either the coding or CDI staff—will need to query for it.

**Editor’s note:** Yuen is an ACDIS Advisory Board member. She previously served as a corporate director of CDI at Penn Medicine, where she oversaw four hospitals and was successful in developing a unified and multidisciplinary corporate CDI process focused on improving physician/provider documentation and accurate CDI financial reporting. Contact her at anny.p.yuen@gmail.com.