# ICD-10: What Every Hospital Executive Should Prepare For?

Nena Scott, MSEd, RHIA, CCS, CCS-P

ICD-10-CM/PCS - Certified Trainer and Ambassador

Course Objectives

- **Introduce the ICD-10-CM/PCS classification system and explain its purpose and importance.**

- **Review the history, current use and benefits of the ICD system.**

- **Provide a detailed look at changes in the new system and how ICD-10-CM/PCS will affect healthcare professionals and departments.**

- **Explore the impact of the ICD-10-CM/PCS transition while gaining familiarity with various departments and professionals within a typical healthcare facility.**

ICD-10-CM/PCS
>>>>>>>>>>>>>>>
An Introduction
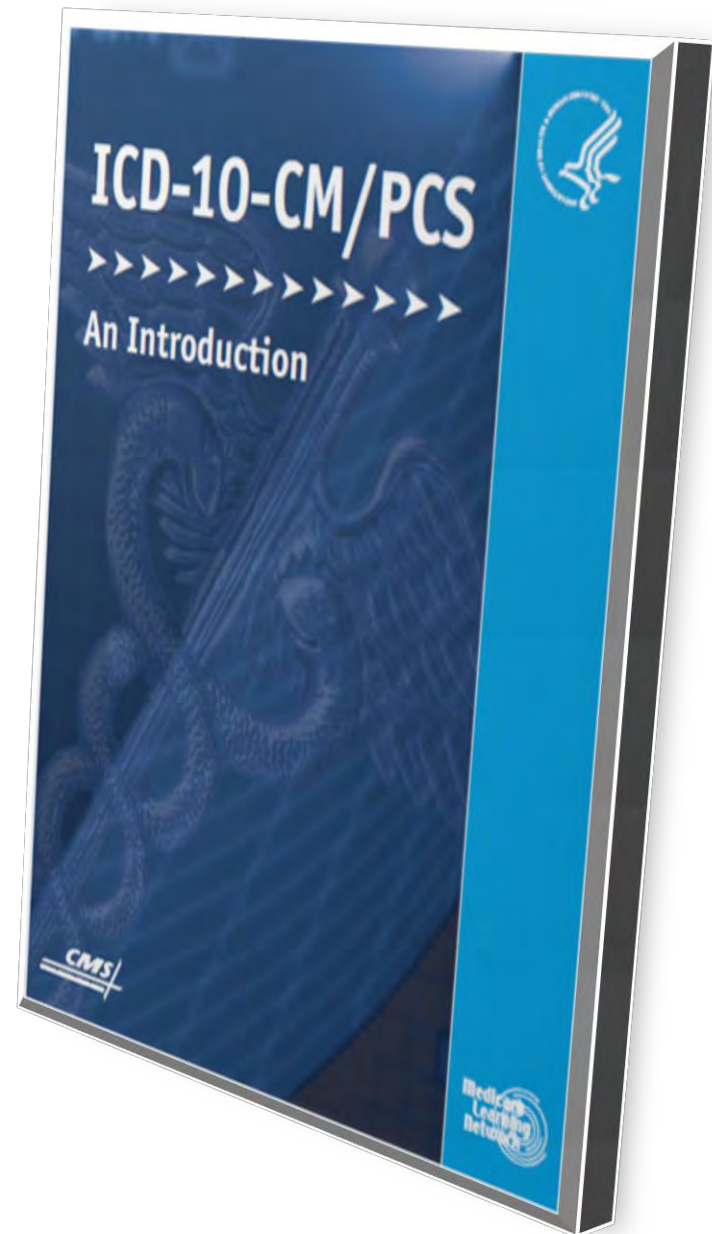
Why Change to ICD-10 Now?

1. Payers cannot pay claims fairly using ICD-9, since the classification does not accurately reflect current technology.

   Significantly different diagnoses and procedures are assigned to a single ICD-9 code.

   These limitations are translating directly into limitations in the DRG groups and, therefore, the resulting payments.

2. The healthcare industry cannot accurately measure the quality of care using ICD-9.

   It is difficult to evaluate the outcome of new procedures and emerging healthcare conditions when codes are not precise.

   Most importantly, the industry has a mission to improve its ability to provide patient care, which is limited by ICD-9-CM.

Worldwide ICD-10 Adoption

Canada
- Began adopting in 2001
- Over 5-year implementation
- ICD–10–CA for morbidity
- Coding is used for statistical purposes rather than for billing

United Kingdom
- Adopted in 1995

Germany
- Adopted in 1998
- ICD–10–AM for morbidity
- Implementation took 3 years

Russia
- Adopted in 1999

China
- Adopted in 2002

Brazil
- Adopted in 1998

France
- Adopted in 1996

Australia
- Adopted in 1998
- Implementation took 2 years
- 2 years from decision to change to actual implementation was insufficient lead time to build the classification and educate users

South Africa
- Adopted in 1996

SOURCE: World Health Organization

What is ICD-10-CM?

ICD-10-CM Replaces ICD-9-CM Volume 1 and 2

ICD-10-CM…

- ✓ ICD-10-CM is built on our current ICD-9-CM coding system, with a few modified conventions and the incorporation of a new code format and nomenclature, or naming system.
- ✓ Like ICD-9-CM, ICD-10-CM is an arrangement of similar diseases, and other conditions based on approved criteria.
- ✓ Diseases can be grouped in a variety of ways: etiology, anatomy, site, type of disease and morphology. In ICD-10-CM, the most frequently used axis for most categories is anatomy.

CMS / ICD-10
CENTERS FOR MEDICARE & MEDICAID SERVICES
Official CMS Industry Resources for the ICD-10 Transition
www.cms.gov/ICD10

Benefits of ICD-10-CM

- Improved measurement of quality, safety and efficiency of health care

- Reduced need for extra documentation describing patient's condition, for reimbursement purposes

- Enhanced payment system design

- More detailed research data for clinical trials and epidemiological studies

- Streamlined and less cumbersome health care delivery procedures

- Prevention of fraud and abuse

- Enhanced tracking of public health and risk

Difference in Appearance

ICD-9-CM	ICD-10-CM
▪ Consists of three to five characters ▪ First character is numeric or alpha (*E* or *V*) ▪ Second, third, fourth and fifth characters are numeric ▪ Always at least three characters ▪ Decimal placed after the first three characters	▪ Consists of three to seven characters ▪ First character is alpha ▪ All letters used except *U* ▪ Second and third characters are numeric ▪ Fourth, fifth, sixth and seventh characters can be alpha or numeric ▪ Decimal placed after the first three characters

ICD-9-CM Code Format

X X X . X X

category   etiology, anatomic site, manifestation

ICD-10-CM Code Format

X X X . X X X X

category   etiology, anatomic site, severity   extension

Alpha Character

	S	6	4	.	4	9	0		A

Category — Etiology, Anatomic Site, Manifestation — **Extension**

Here are some examples…

Code	Description
E08.22	Diabetes mellitus due to an underlying condition with diabetic chronic kidney disease
T81.535	Perforation due to foreign body accidently left in body following heart catheterization
I25.110	Arteriosclerotic heart disease of native coronary artery with unstable angina pectoris
C50.212	Malignant neoplasm of upper-inner quadrant of left female breast

Alpha Character

A-B Infectious/Parasitic Diseases

C Neoplasms

D Diseases of Blood/Blood-Forming Organs

E Endocrine, Nutritional, and Metabolic Diseases

F Mental and Behavioral Disorders

G Diseases of the Nervous System

H Diseases of the Eye and Adnexa
Diseases of the Ear and Mastoid Process

I Diseases of the Circulatory System

J Diseases of the Respiratory System

K Diseases of the Digestive System

L Diseases of Skin and Subcutaneous Tissue

M Diseases of Musculoskeletal System

N Diseases of the Genitourinary System

O Pregnancy, Childbirth, and the Puerperium

P Certain conditions originating in perinatal

Q Congenital malformations, deformations, and chromosomal abnormalities

R Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified

S-T Injury, poisoning, certain other consequences of external causes

V-Y External causes of morbidity

Z Factor influencing health status

Three-Character Category Code

L	2	2
	Category	

Etiology, Anatomic Site, Manifestation

Extension
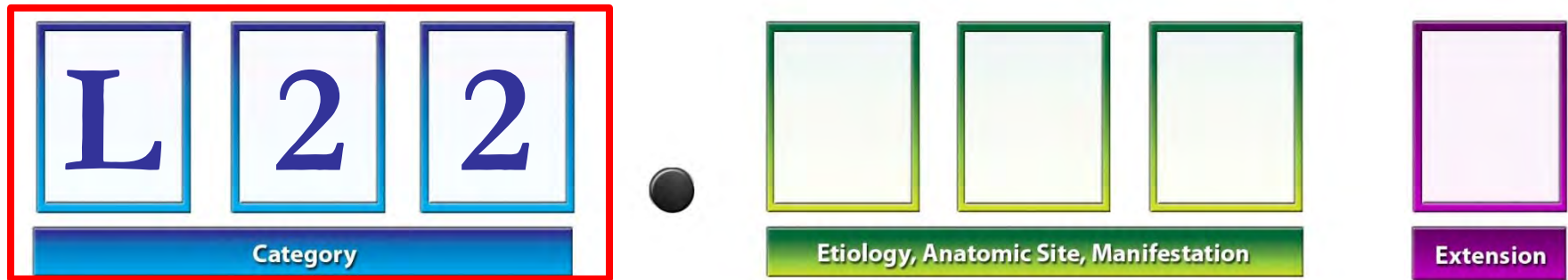
ICD-10-CM also uses categories and subcategories to group similar codes together, as in ICD-9-CM. All categories start with three characters just as they are in ICD-9-CM, but in ICD-10-CM, these begin with a specific alpha character that identifies the disease category.

It is important to note that three-character codes are allowed in ICD-10 as long as it does not further subdivide, or add specificity, after the decimal point.

There are about 300 three-digit ICD-10-CM codes, so it is not incorrect to receive a three-digit code from a provider. But, three-character codes are rare and should be checked for completeness.

Three-Character Category Code
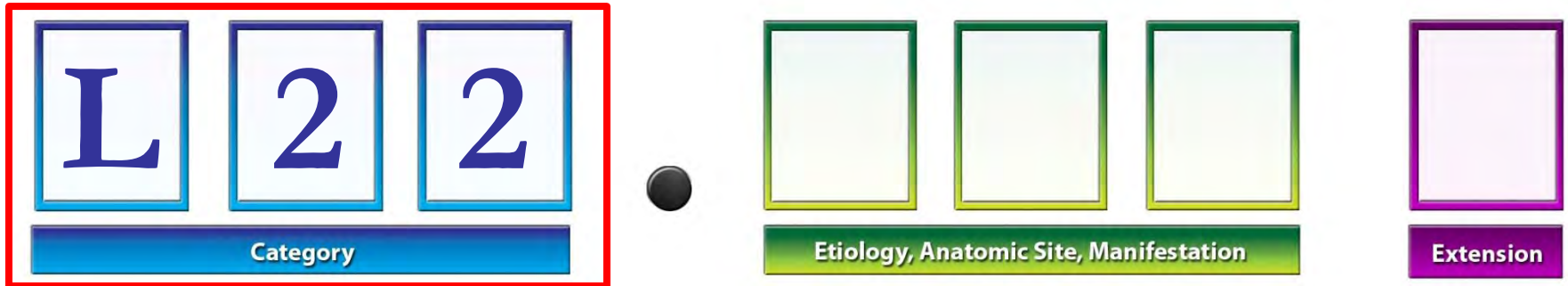
This is the code for *Diaper rash dermatitis,* which is considered a complete code because it is not further sub-divided after the first 3 listed characters.

Here are some examples of other three-character category codes:

G10	**Huntington's disease**
H28	**Cataract in diseases classified elsewhere**
I00	**Rheumatic fever without heart involvement**
J60	**Coalworker's pneumoconiosis**

Four-Character Category Code

S	6	4	.	4				
Category				**Etiology, Anatomic Site, Manifestation**				**Extension**

The four-character code is the most common length of codes in ICD-10-CM. The fourth character is used as a way to add further specificity in disease process, anatomical site, laterality, patient history and other notable information.

Here are some examples of four-character category codes:

L04.0   **Acute lymphadenitis of face, head and neck**

M18.4   **Other bilateral secondary osteoarthritis of first carpometacarpal joint**

O28.0   **Abnormal hematological finding on antenatal screen of mother**

P78.0   **Perinatal intestinal perforation**

The Whole Code

S 6 4 . 4 9 0 A

Category — Etiology, Anatomic Site, Manifestation — Extension

The addition of the fifth and sixth characters creates greater code specificity. Each ICD-10-CM code description is complete, so there are no additional places to look for a continuation of codes except the extension character in the seventh position.

Here are some examples of whole codes:

Code	Description
R10.813	Right lower quadrant abdominal tenderness
S51.031	Puncture wound without foreign body of the right elbow
T23.611	Corrosion of second degree of right thumb (nail)
V23.4xxS	Motorcycle driver injured in collision with car, pick-up truck or van in a traffic accident, sequela

Extensions and Placeholders

S	6	4	.	4	9	0	A
Category				**Etiology, Anatomic Site, Manifestation**			**Extension**

Two new concepts and format changes in ICD-10-CM were put into place
to allow growth in the system over time. They are:

Extension characters and Placeholder characters

The addition of the seventh character is a critical element of the transition to
ICD-10-CM because many disease categories and code groups require its inclusion.

If this character is not included when required, the code will be considered
incomplete and rejected either by compliance checkers or in the billing editor.
For this reason, appropriate documentation of level of care is needed.

Extension Characters

S	6	4	.	4	9	0	A
Category				**Etiology, Anatomic Site, Manifestation**			**Extension**

The seventh character extension allows codes for certain conditions to convey further specificity about the condition being coded, while still keeping the code count to a manageable size.

The extension can be alpha or numeric and must always be the seventh character.

O35.0xx1   Maternal care for (suspected) central nervous system malformation in fetus, **fetus 1**

S06.0x1S   Concussion with loss of consciousness of 30 minutes or less, **sequela**

S22.000K   Wedge compression fracture of unspecified thoracic vertebra, **subsequent encounter for fracture with nonunion**

Placeholder Characters

V	2	3	.	4	X	X		A
Category				**Etiology, Anatomic Site, Manifestation**				**Extension**
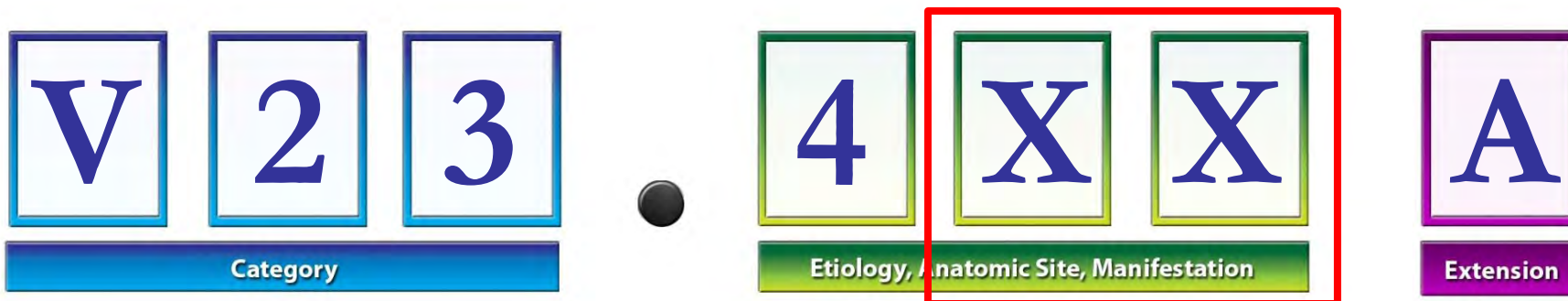
The other change is the **dummy placeholder.**
The placeholder is **always the letter _X_.** This placeholders serve two uses:

1. **As the fifth character for certain six character codes,** the _X_ allows
for future expansion without disturbing the sixth character structure.

2. **When a code has less than six characters and a seventh character extension
is required,** the _X_ is assigned for all characters less than six, so the code meets
the requirement that all codes with an extension must have seven characters.

Examples of Placeholders

| V | 2 | 3 | . | 4 | X | X | | A |
| Category | | | | Etiology, Anatomic Site, Manifestation | | | | Extension |
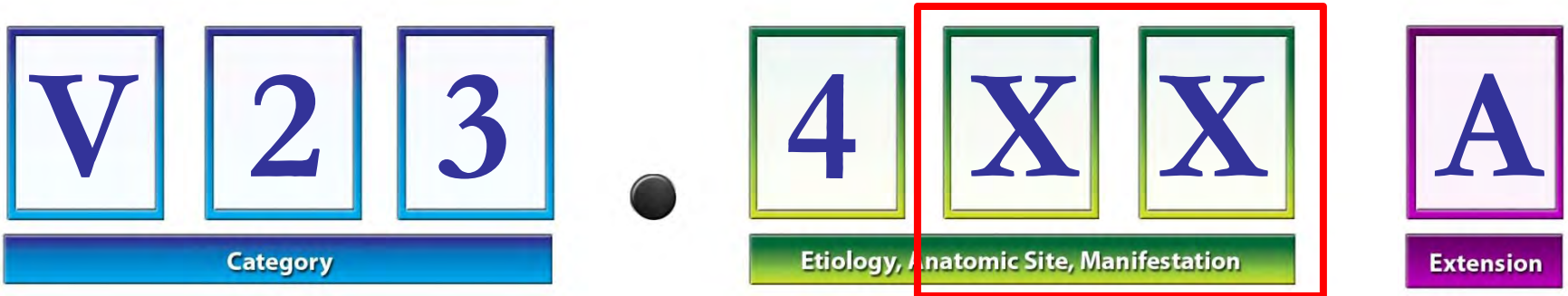
Here are some examples of Placeholders:

X93.xxx**A**   **Assault by handgun discharge,** initial encounter

S17.0xx**A**   **Crushing injury of larynx and trachea, initial encounter**

T70.0xxS   **Otitic barotrauma,** sequela

What is ICD-10-PCS?

ICD-10-PCS Replaces ICD-9-CM Volume 3

ICD-10-PCDS...

- Is used to represent procedures

- Does not take the place of CPT or Chargemaster driven codes

- Allows for more accurate codes to reflect changes in medicine

New procedure codes are always being added and while
the current system is limited on its ability to grow,
ICD-10-PCS allows for the expansion.

ICD-10-PCS
Additional Attributes

- Diagnostic information has been excluded from the procedure descriptions to enhance data collection. In ICD-9, they were often included.

- The level of specificity has increased so that all procedures currently performed are captured in ICD-10-PCS.

- All those who code, interact with codes or document in the medical record must understand the additional information contained within the code and the documentation required to allow construction.

ICD-10-PCS
Code Format

ICD-10-PCS Code Format

ICD-9-CM Volume 3	ICD-10-PCS
▪ Follows ICD structure for diagnosis coding	▪ Designed for a procedural coding
▪ Codes in fixed or finite list form	▪ Codes constructed from values/tables
▪ Codes are numeric	▪ Codes are alpha-numeric
▪ Codes are three to four digits long	▪ All codes are seven characters long

ICD-10-PCS Code Format

Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
Medical And Surgical	Hepatobiliary System and Pancreas	Resection	Gallbladder	Percutaneous Endoscopic	No Device	No Qualifier
0	F	T	4	4	Z	Z

Character 1 - Section

The first character in the code determines the broad procedure category, or Section, where the code is found. In our example *0* is Medical and Surgical.

Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
Medical And Surgical	Gastro-intestinal	Resection	Sigmoid Colon	Open	No Device	No Qualifier
0	D	T	N	0	Z	Z

Sections

The Section values represent the general type of procedure.
There are 16 sections as seen below:

Medical and Surgical Related Sections

0   Medical and Surgical
1   Obstetrics
2   Placement
3   Administration
4   Measurement and monitoring
5   Extracorporeal assistance and performance
6   Extracorporeal therapies
7   Osteopathic
8   Other procedures
9   Chiropractic
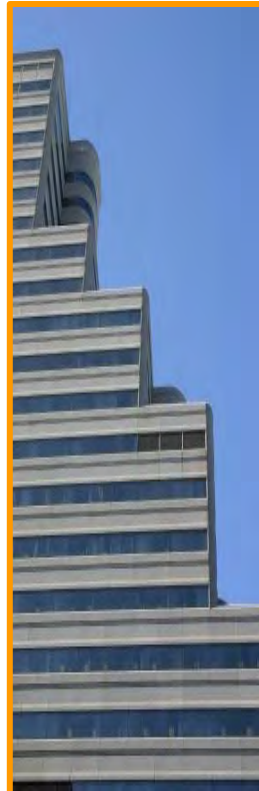
Ancillary Sections

B   Imaging
C   Nuclear medicine
D   Radiation oncology
F   Physical rehabilitation and diagnostic audiology
G   Mental Health
H   Substance abuse and treatment

Character 2 - Body System

The Body System character notes the general body system where the procedure is performed. Each body system has a different value, which makes it easy to identify the general region of the procedure.

Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
Medical And Surgical	Gastro-intestinal	Resection	Sigmoid Colon	Open	No Device	No Qualifier
0	D	T	N	0	Z	Z

In this example, *D* represents the **Gastrointestinal system**.

Character 2 - Body System

0. Central nervous system
1. Peripheral nervous system
2. Heart and great vessels
3. Upper arteries
4. Lower arteries
5. Upper veins
6. Lower veins
7. Lymphatic and hemic system
8. Eye
9. Ear, nose, sinus
B. Respiratory system
C. Mouth and throat
D. Gastrointestinal system
F. Hepatobiliary system and pancreas
G. Endocrine system
H. Skin and breast

J. Subcutaneous tissue and facia
K. Muscles
L. Tendons
M. Bursa, ligament
N. Head and facial bones
P. Upper bones
Q. Lower bones
R. Upper joints
S. Lower joints
T. Urinary system
U. Female reproductive system
V. Male reproductive system
W. Anatomical regions, general
X. Anatomical regions, upper extremities
Y. Anatomical regions, lower extremities

Character 3 - Root Operation

The **Root Operation** is the objective of the specific procedure. Each section (first character) has different procedural objectives, making Root Operation one of the more challenging aspects of ICD-10-PCS.

From our example of a sigmoid colectomy, the root operation is **resection—cutting out or off, without replacement, all of a body part.**

Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
Medical And Surgical	Gastro-intestinal	Resection	Sigmoid Colon	Open	No Device	No Qualifier
0	D	T	N	0	Z	Z

In this example, *T* represents the **Root Operation** of **Resection.**

Character 3 - Root Operation

Root Operations for the Medical and Surgical Section			
Alteration	Division	Inspection	Reposition
Bypass	Drainage	Map	Resection
Change	Excision	Occlusion	Restriction
Control	Extirpation	Reattachment	Revision
Creation	Extraction	Release	Supplement
Destruction	Fragmentation	Removal	Transfer
Detachment	Fusion	Repair	Transplantation
Dilation	Insertion	Replacement	

Character 4 - Body Part

This is the **Body Part** or specific anatomical site where the procedure was performed. The body system is very general and is used for general site identification, but the body part is very specific to the procedure site.

Examples: **KIDNEYS, TONSILS** and **THYMUS.**

Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
Medical And Surgical	Gastro-intestinal	Resection	Sigmoid Colon	Open	No Device	No Qualifier
0	D	T	N	0	Z	Z

In this example, the *N* represents the **sigmoid colon**.

Character 5 - Approach

The fifth character is the **Approach** and it identifies the technique used to reach the procedure site. There are different approaches based upon each section.

In our example, the **Approach** is **Open**, so *0* is utilized.

Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
Medical And Surgical	Gastro-intestinal	Resection	Sigmoid Colon	Open	No Device	No Qualifier
0	D	T	N	0	Z	Z

Character 6 - Device

The **Device** character specifies devices that remain after the procedure is completed. The device character is different for each section.

Z is a value used in the ICD-10-PCS system that means no or not applicable to this code.

Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
Medical And Surgical	Gastro-intestinal	Resection	Sigmoid Colon	Open	No Device	No Qualifier
0	D	T	N	0	Z	Z

In our example, there was no device, so the character is *Z*.

Character 7 - Qualifier

A **Qualifier** is an additional attribute of the procedure if applicable. Examples of qualifiers include **DIAGNOSTIC** or **STEREOTACTIC**. Qualifier choices vary depending on previous values selected. As an example, in the Obstetrics section, qualifiers can identify the type of extraction (low forceps), type of fluid removed during drainage procedure (amniotic), or type of cesarean section performed.

Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier
Medical And Surgical	Gastro-intestinal	Resection	Sigmoid Colon	Open	No Device	No Qualifier
0	D	T	N	0	Z	Z

In our example, there is no qualifier, so the value is Z.

The Impacted Populations

In this walkthrough, of a sample facility it is designed to highlight some, not all, of the different impacted populations within a typical facility.

The sample facility is broken into three floors by type of activity. These are:

- 1st Floor - Patient experience

- 2nd Floor - Data creation

- 3rd Floor - Data use

1st Floor – Patient Experience

- Pre-registration staff
- Registration staff
- Nurses
- Physicians
- Ancillary services

REGISTRATION

ICD-10 and Pre-Registration

Pre-registration

Pre-registration personnel will need ICD-10-CM code assignment and interpretation knowledge to book physician-managed services such as operative procedures or ancillary services. Staff need clinical-level training to prepare for ICD-10, so they can:

- Communicate with providers and hospital staff concerning use of ICD-10-CM

- Oversee software for diagnostic, therapeutic and procedural reservations: English vs. code

- Coordinate with other staff concerning reserved appointment times and services
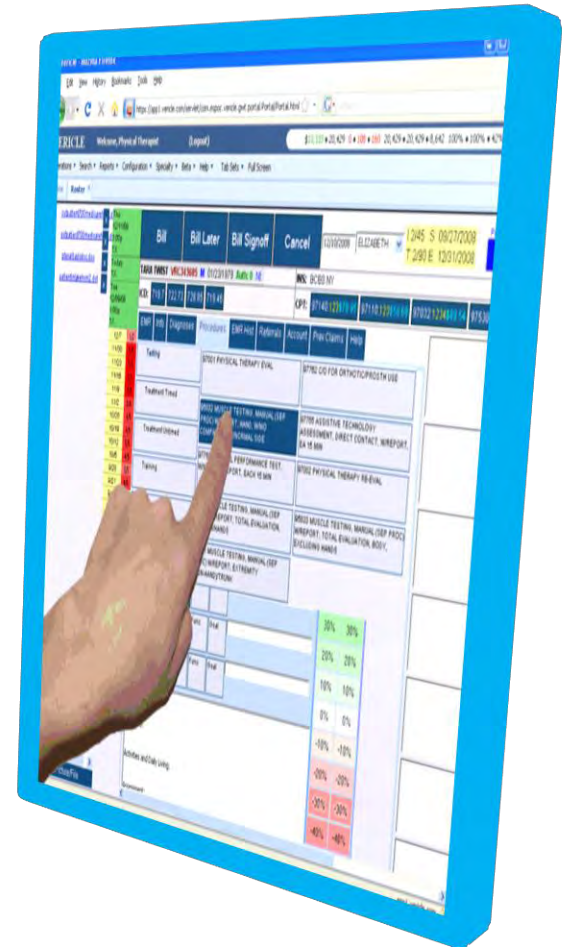
Pre-Registration and Scheduling

IMPACT OF ICD-10 →

The effects of ICD-10 will be felt most significantly in **productivity.**

Key Impacts

- Extra time will be required to verify ICD-10 codes, both in correct code selection and validation of code completion.

- New Medically Unlikely Edits (MUEs) and National Correct Coding Initiative (NCCI) Edits must be learned and understood by staff.

- The process for receipt of physician orders will have to be reviewed, and decisions made on whether ICD-10 codes will be accepted due the high error rate expected at all levels at the onset of the ICD-10 transition.

To prepare for the transition, education is key…

ICD-10 and Registration

Registration

Registration staff will need basic training in ICD-10-CM and ICD-10-PCS. Increased specificity in the ICD-10 code set will have a positive effect on the registration department. Issues will relate to code interpretation and communication.

- Staff will need clinical-level training for ICD-10

- There must be assurance that complete codes are used for diagnostic and ancillary procedures.

- Management must review, with each vendor, all electronic applications used in registration, compliance checking, insurance verification and order entry procedures to verify timelines for ICD-10-CM upgrades.

ICD-10 and Nursing

- **Nurses will need clinical documentation training for ICD-10 , especially as it pertains to specificity of codes and documentation required to support assignments.**
- **Other areas impacted include:**
  - Charge entry and capture nursing personnel in departments such as OR
  - Software systems that use codes such as labor and delivery (OBIX)
  - Oasis home health coding
  - IRF-PAI for rehab units
  - Clinical pathways

ICD-10 and Physician

- **Due to the increased specificity in documentation required, queries are expected to increase 10 to 50% causing major impacts on physician workloads.**

- **Productivity losses among physicians are expected to range from $50 million to $250 million before they achieve ICD-10 proficiency.** **Prompt education** **may greatly reduce this estimate.**

- **Physicians face a permanent workload increase of three to four percent. Enhancing specificity is not only essential for the hospital and coder, but also in order for the physician to avoid these work impacts.**

ICD-10 and Ancillary Services

Ancillary providers need education for ICD-10-CM only, to successfully manage:

- Documentation review and audit

- Operational flow charting: the collection, submission and routing of data

- New processes and procedures pertaining to systems, forms and workflows

- CPT and HCPCS codes, that will still be used for charge masters, procedure description and charging

ICD-10 and Case Managers

Payers will be forced to monitor every process to determine medical necessity, appropriateness of care, referrals, utilization, authorization and certification. In turn, nurse case managers will need to gain clinical-level ICD-10-CM knowledge to assist in:

- Documentation gap analysis to ensure compliance

- Physician education on documentation

- GEMS (crosswalk between ICD-9-CM and ICD-10-CM)

- Impact studies on each department, including budgeting

- HEDIS (managed care performance measurement tool)

2nd Floor – Data Creation

- HIM Directors
- HIM Staff
- CTRs
- Coders
- IT Department
- Finance/PFS

ICD-10 and HIM

The HIM Director should oversee:

- **Education to appropriate levels of competence**
  - ○ **Anatomy & Physiology, Coding, General ICD-10**
  - ○ **Learning level assessment by department**
  - ○ **Full ICD-10-CM training versus sufficiency to manage the coding and DNFB functions**
- **Needs analysis and action planning for the transition**
- **Information systems inventory and gap analysis**
- **Vendor preparation**
- **Documentation improvement resources**
- **Payer preparation, reports and financial issues**
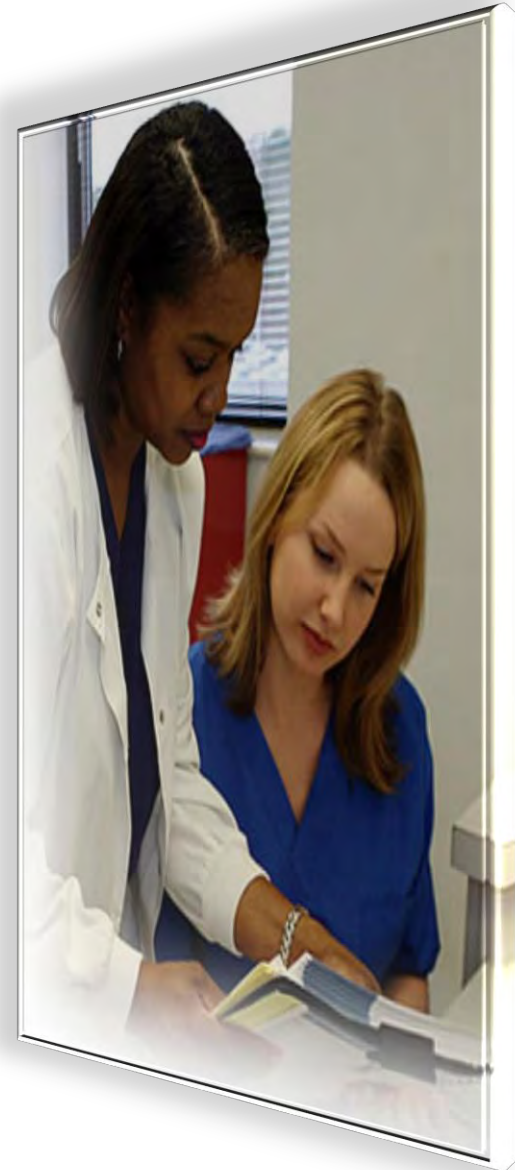
ICD-10 and HIM Staff

Monitoring for optimal process flow and record completion in the **HIM department** will be essential during the transition from ICD-9 to ICD-10, with an eye toward reducing negative impacts on the revenue cycle.

Important pre-transition projects should start now with a process flow analysis and process redesign. HIM directors will want to focus on:

- Basic level training in ICD-10 will be required

- Average record completion time

- Common backlog areas in HIM

- Data interface with coded material, even if not utilized by the end user

- Timely record retrieval and management of in-house patient records
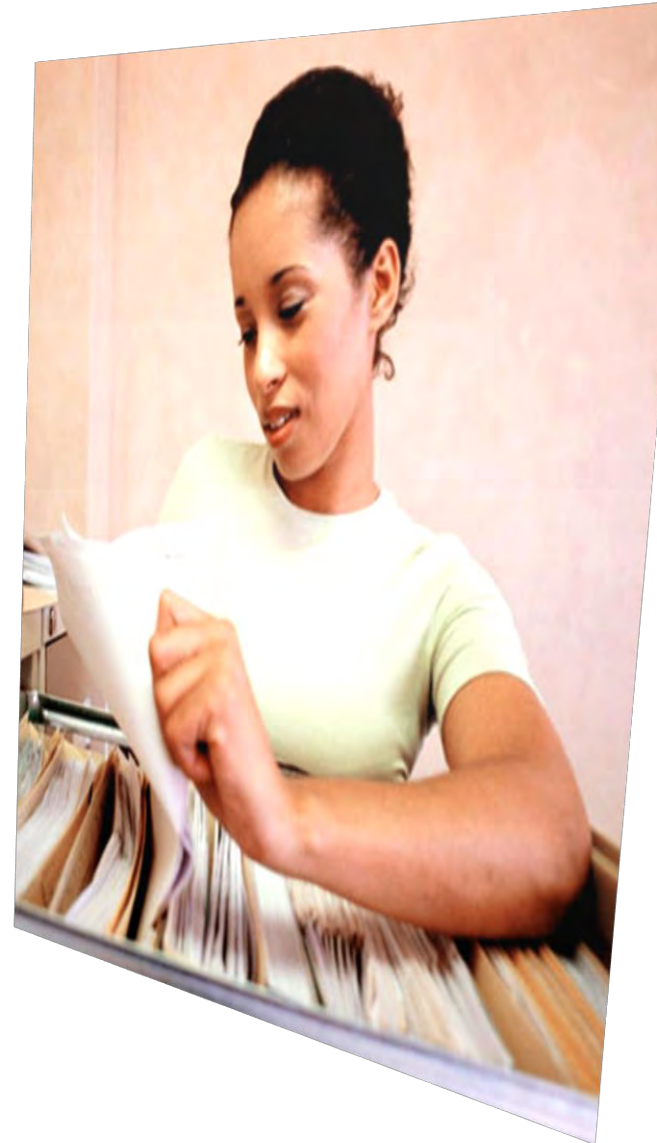
ICD-10 and Certified Tumor Register (CTR)

CTRs face significant changes…

Just as with coding, **CTRs** routinely face changes in their reference materials. And in the next three years, all of these changes will come into effect all at once.

- CTRs will need to understand the basics of ICD-10, but many CTRs may require a more detailed understanding of the classification system for the abstraction portion of their work.

- CTRs abstract cancer patients' co-morbid conditions from the HIM coders' coding summary list, requiring full understanding of ICD-10.
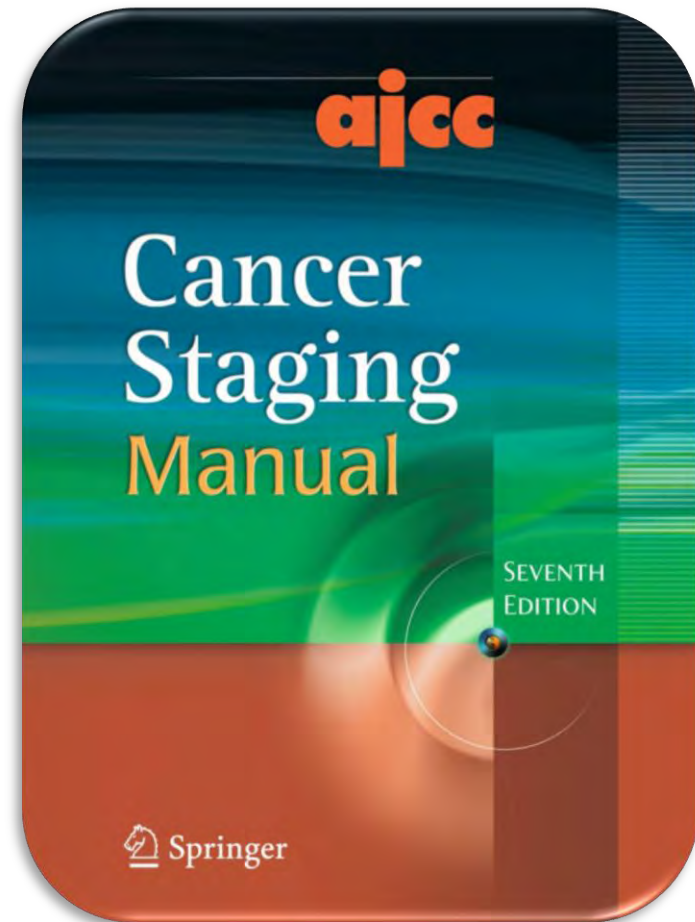
ICD-10 and Inpatient Coders

The most important things coding professionals can do is to start early and strengthen their Anatomy & Physiology knowledge as much and as early as possible.

- **Inpatient coders** will need the full coder ICD-10 training which covers ICD-10-CM and ICD-10-PCS.

- It is essential to prepare for the training and education ahead by taking a Coding Readiness Assessment to identify areas that need improvement.

- All coders will need to take *Anatomy & Physiology* education as soon as possible, and maintain study and practice in the years preceding 2013.
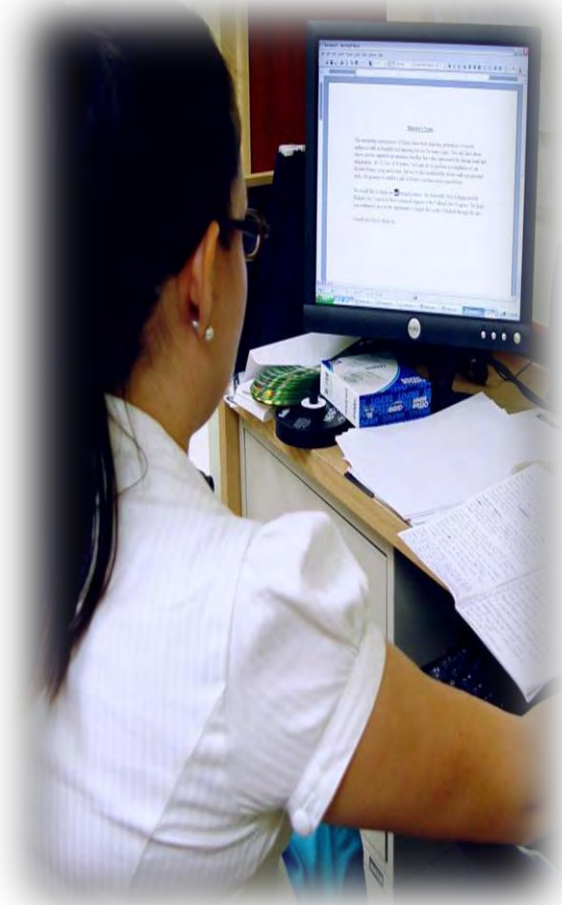
ICD-10 and Outpatient Coders

- **Outpatient coders** will not be required to learn the ICD-10-PCS system, only ICD-10-CM resulting in less required education than the inpatient coder. Medical necessity and diagnostic coding is a major part of an outpatient coder's skill set.

- ICD-10-CM is being adopted by outpatient services for use in diagnostic coding and reporting.

- ICD-10-PCS, the procedural portion of the new classification, will **not** be used by the **OPPS** .

ICD-10 and Information Technology

The information systems transition should begin now. The 5010 transition is slotted for completion at the end of 2011. Today and through implementation, IT should be involved in these tasks…

- IT should take basic level education on ICD-10-CM, but also may require education on the ICD-10 GEMs, which is a system of mapping codes between ICD-9 and ICD-10.

- Participate as a member of the ICD-10-CM Steering Committee.

- Complete information systems surveys and inventory assessment.

- Evaluate vendor readiness and support.

- Review contractual agreements with software vendors and ensure ICD-10 implementation is considered in all future software application purchases.

- Identify areas requiring operational and policy changes.

ICD-10 and Finance

Finance will face the second largest system change in the hospital cycle. All the systems used to process claims will have to be converted to 5010. Some areas to include in plan development are: assessment and gap analysis, budgeting, development, testing, education, implementation and communication.

Additional steps that finance departments must take:

- Financial personnel will need basic ICD-10 education and specific *Finance and Reimbursement* education to understand the differences in Reimbursement.
- Review and/or bolster contracting and reimbursement mechanisms.
- Confirm payer and business associate for both 5010 and ICD-10-CM.
- Internally review all processes and supporting systems associated with electronic exchange of information with payers to ensure they accommodate ICD-10 codes.
- Update any clinical and quality reporting with payers to include ICD-10 codes.

ICD-10 and Quality Assurance

The issues of medical errors, fragmented care and inadequate systems such as ICD-9-CM), impact the ability of individual **quality assurance departments** to optimally perform their job.

In addition to its payment implications, the transition from ICD-9 to ICD-10 offers notable opportunities for hospitals and health systems to code more accurately and contribute to healthcare quality improvement initiatives.

Quality assurance personnel can prepare by…

1. Taking clinical level ICD-10 education
2. Developing methods for controlling the documentation of care and treatment for clinical and financial purposes
3. Evaluating policies and procedures
4. Maintaining older data
5. Learning to use GEMs
6. Improving physician documentation
7. Reviewing HIM query volume and trends
8. Completing information systems assessment inventory

What is the Revenue Cycle?

Now, we have all heard the term revenue cycle (RC) before, but it is essential that we understand what it is and the impact of ICD-10 within it.

"The revenue cycle is all administrative and clinical functions that contribute to the capture, management and collection of patient service revenue."*

*HFMA

So, the revenue cycle is not just about billing, but the entire flow of a patient and medical record through a hospital. It affects all levels of healthcare.

It includes some of the following: Patient Access/Pre-Registration Clinical Care… Clinical Services… Case Management… HIM/Coding… Billing… Claims Denial… and Cash Collection.

Take Advantage of Change

Healthcare payment levels are expected to continue to decline as a result of trends in the economy and government programs designed to control cost, fraud and abuse.

But, despite these trends, hospitals have a unique opportunity to review their financial performance while they are evaluating the impact of ICD-10 and Meaningful Use on current processes.

Revenue Cycle Management

- The **revenue cycle team** will need basic ICD-10 education as well as specific ICD-10 *Finance and Reimbursement* education.

- The team should be involved in each department's process gap analysis for optimizing the revenue cycle, to mitigate the transitional lags that will occur.

- The revenue cycle team should also be closely aligned with the ICD-10-CM steering committee.

3rd Floor – Data Use

- Quality Assurance
- Utilization Review
- Claims Review
- Senior management
- Compliance
- Human resources

ICD-10 and Utilization Review

- **Utilization review staff** will need clinical level, GEMS, and Reimbursement ICD-10 education.

- UR managers must be able to:
  - Document GAP analysis projects
  - Maintain physician education on documentation
  - Ensure registry staff gain training
  - Become GEMs experts (GEMs is the crosswalk between ICD-9-CM and ICD-10-CM)
  - Assist in impact studies on each department and address budgetary considerations

ICD-10 and Claims Review

- The claims review personnel within the facility will require clinical level and GEMS ICD-10 education.

- The testing and computer test runs will need to focus on:
  - Incorrect ICD-10-CM/PCS code lengths
  - Missing dummy place holders
  - Missing seventh character extensions
  - Incorrect ICD-10-CM/PCS designation on UB-04
  - Operation of the new ICD-10-CM/PCS edits
  - All of the revenue cycle data issues that were unresolved in the ICD-9 period, such as guarantor, address, social security number, invalid ID cards and more

ICD-10 and Senior Management

- Senior leadership will need to take basic level ICD-10 education as well as possibly *GEMs* and *Finance/Reimbursement* education.

- Introductory ICD-10-CM/PCS education for management personnel should be a priority.

- Management must oversee facility-wide ICD-10-CM/PCS implementation.

- Production and budgetary data for each impacted hospital department will need to be incorporated into a single cohesive plan.

ICD-10 and Compliance

Every study that has been published, in the U.S. and worldwide, cites the potential of perceived fraud due to errors in coding.

Compliance leadership will need clinical level ICD-10 education to understand documentation impacts.

And the compliance department must examine new coding structure and rules while emphasizing the following:

- Proper documentation
- Impact on compliance areas
- Compliance checking systems
- Compliance education for ICD-10-CM based on documentation gap analysis
- The necessary level of education in ICD-10
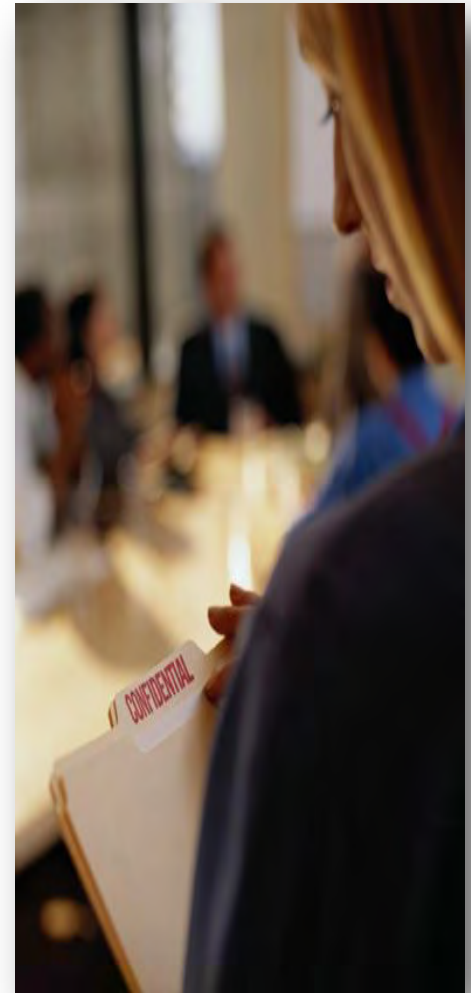
ICD-10 and Human Resources

First steps in preparing HR personnel for ICD-10…

- Require basic ICD-10 education
- Evaluate policies and procedures
- Implement policies for optimal hiring of personnel with previous training
- Create pre-employment tests for the transition
- Change corresponding job descriptions
- Develop employee retention strategies
- Investigate and share wage and benefit statistics

Clinical Documentation

One major underlying issues with the advent of ICD-10 is that many documenters of the medical record do not think about or understand the relationship between their documentation in record and the billing process.

Understanding that only documented services may be billed is essential to successful transition to ICD-10.

The Documenters

This group includes but is not limited to:

- The Physician
- The Nurse
- The Dietitians
- The Pharmacist
- Lab
- Radiology
- Nuclear Medicine
- Respiratory Therapy
- GI Lab
- Heart Cath Lab

- Consultants
- The Surgical Team
- Anesthesiologists
- Pathologists
- ER Physicians
- ER Nurses
- Physical Therapist
- Social Workers
- Case Managers

ICD-10 and Clinical Documentation

Key Objectives

The key objectives of **clinical documentation** for a hospital are to…

- **Ensure that admission orders are clear and legible with the correct level of care to support the reason for admission.**

- **Review and cross-check patient demographics and guarantor information to be correct and complete.**

- **Provide a complete, accurate and timely patient's medical history and physical within 24 hours of admission.**

- **Ensure that patient's assessment, procedure notes, clinical plan, progress notes and all other documentation of diagnostic and therapeutic tests are completed within one business day of administration.**

- **Conduct daily review of recommendations from case management to confirm that all treatment given has been documented in the medical record and reflects patient severity of illness and use of services.**

ICD-10 and Clinical Documentation

Impact of ICD-10
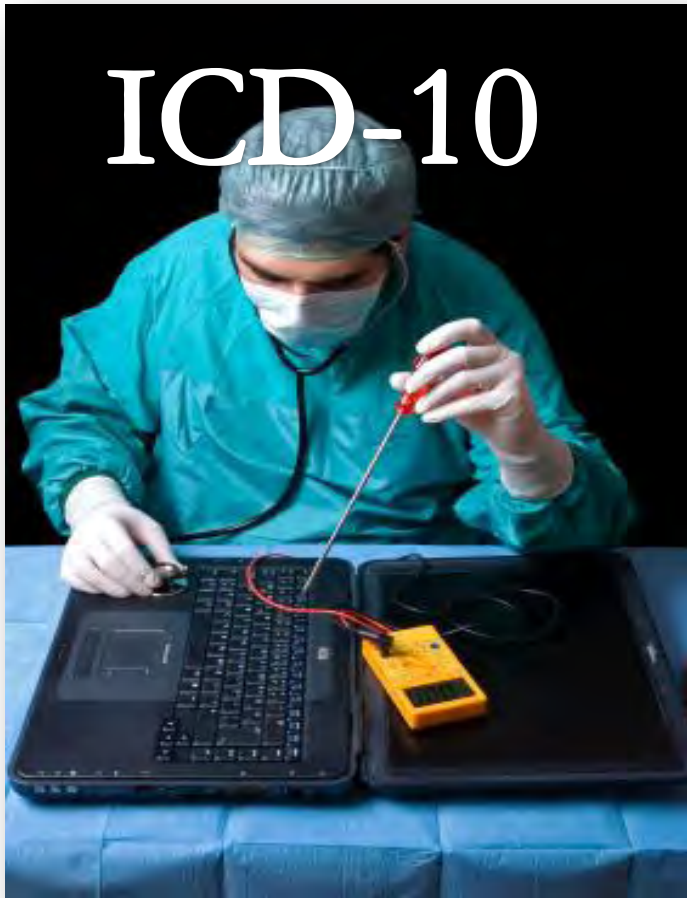
- ICD-10 will impact the new Meaningful Use (MU) requirements for the Computerized Physician Order Entry (CPOE) in relation to diagnoses granularity and specificity of the disease process.

- Physicians will face the need to document diagnoses with information about acuity, type, origin and manifestations to support severity and use of services for treatment of patient's specific disease process, to meet hospital and medical necessity requirements.

- CDI tracking tools will use ICD-10 codes and descriptions, therefore training is critical.

- A good foundation in SNOMED CT will aid all providers in managing new requirements.
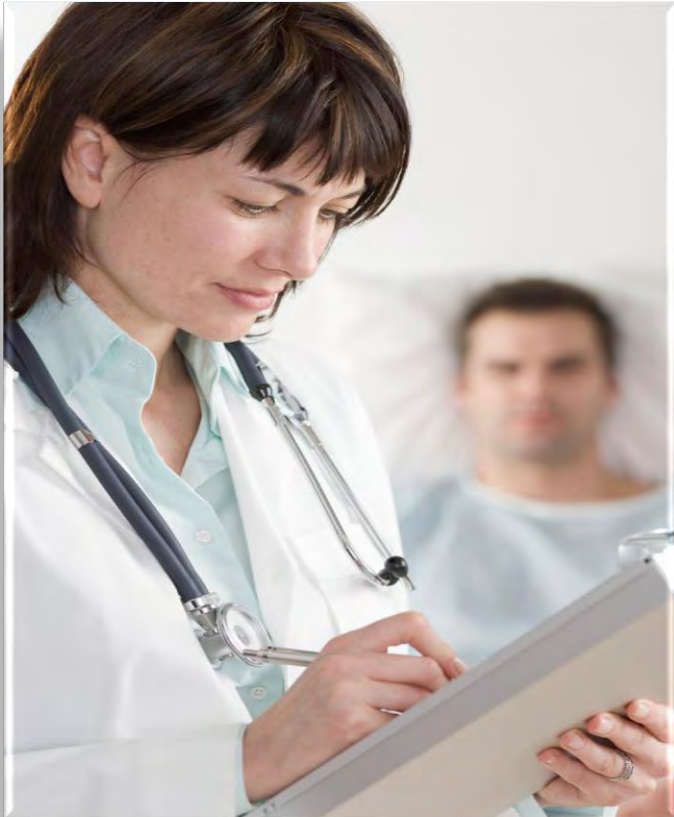
ICD-10 and The Physician Documentation

Key Objectives

The key objectives of the physician's clinical documentation are to…

- Ensure that admission orders are clear and legible with the correct working diagnosis – that is, the reason for the admission and a list of the tests, therapies and procedures that must be completed to diagnose the patient.

- Ensure a complete, accurate and timely documentation of the patient's medical history at admission.

- Direct and coordinate activities and documentation associated with patient's assessment, consultations, procedure notes, clinical plan, progress notes and all diagnostic and therapeutic tests and services used to diagnose; and if possible, heal the patient.

- Physicians often document the progress of treatment of a patient as a means of communicating with other healthcare providers. In this case, a detailed medical record as the key component for bill creation is not a key concern.

ICD-10 and The Physician Documentation

Impact of ICD-10

- Physicians will need to understand the global significance of their documentation in the medical record and its impact on the billing process.

- Physicians will need to decide if they wish to learn to code; or, if understanding the documentation specificity is enough for the transition to ICD-10.

- The code descriptors in ICD-10 are very specific and allow for common combinations of comorbidities along with definitive site, laterality, acuity, disease origin, and/or type. These descriptors will help relieve documentation burdens and improve specificity in the record.

ICD-10 and Nursing Documentation

Nursing documentation is like the bridge that connects the pieces of the medical record together. Their documentation fills in the gaps in daily treatment and care among all of the other types of specialized care, from physicians to dietitians.

Nurses must fill out an initial **Nursing Assessment** sheet. The Assessment gathers information about health needs that can be managed by nursing care.

All other nursing charting forms/nursing entries are for support or elaboration of nursing care provided, findings and/or results.

ICD-10 and Nursing Documentation

Impact of ICD-10

ICD-10 requires more details in clinical documentation for problems, assessments, procedures and treatments.

Nurses will be collaborating on meeting the requirements for both ICD-10 and Meaningful Use. Nurses who specialize in informatics will be working with interdisciplinary teams to modify clinical documentation and workflow to allow for increased granularity and specificity in core measures and other quality-of-care issues.

Nurses will also need to be introduced to the concept of the medical record as the basis for the final bill.

ICD-10 and Case Management

Case managers are going to play a pivotal role in the transition to ICD-10.

Case managers are responsible for the audit and review of each encounter to insure it meets the appropriate admission guidelines.

One of their biggest responsibilities is discharge planning. This process is based on diagnostic and treatment information that is contained in the medical record.

Case managers also review and resolve issues concerning correct level of care… disease severity and expected outcomes… coordination of care after the acute visit… and any other issues related to length of stay and quality of care.

ICD-10 and the Case Management

Impact of ICD-10

Case managers will need to evaluate every one of their processes as it relates to determining medical necessity, appropriateness of care, referrals, utilization, authorization and certification.

Case managers should become familiar with ICD-10 codes and advanced clinical treatment guidelines based on the expanded information that will become available through ICD-10.
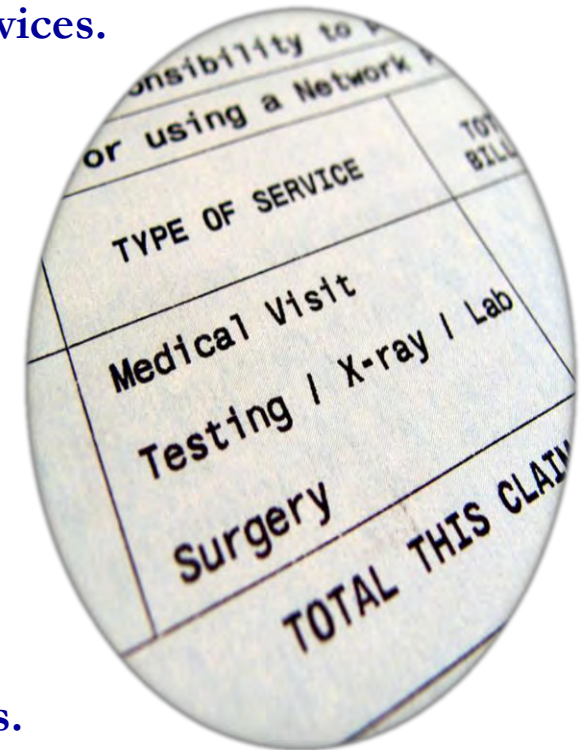
ICD-10 and Charge Capture

Key Objectives

The **charge description master (CDM)** is the most complex master file in the hospital system. Records in the CDM include a line item for every possible charge – including hospital services, all diagnostic and therapeutic procedures, equipment, supplies, drugs and professional services.

- Order-entry items use clinician-interpretable descriptions that accurately map to the service codes, as reported by hospital staff throughout all departments.

- Each department that dispenses goods and services for a patient's care must create a charge ticket and enter the data to the system daily. **This use of goods and services must be supported by medical necessity coding.**

- The charge generation process is used by all hospital departments and in all manner of workflow situations, such as pre-order, post-delivery and results-posted services.

ICD-10 and Charge Capture

Impact of ICD-10

- ICD-10 will impact the CDM in areas such as medical necessity and code mapping, if that process is used by the hospital.

- ICD-10-PCS codes will provide custom codes based solely on the operations and procedures performed on the patient. ICD-10-PCS code mapping to CPT charge codes could promote more accurate payments for specific procedures.

- Lab, radiology and all other ancillary departments still need to understand diagnostics and medical necessity.

ICD-10 and Patient Financial Services

Key Objectives

Patient financial services is where the medical record data is transformed into a bill for services.

First there is a **review of all the data** that has been accumulated on each patient for each encounter.

Patient demographic data, insurance data and codes representing the patient's clinical experience are audited and passed through several systems that will ensure a correct representation of the patient and services rendered.

Codes are the official language of the billing department and they form the basis for support of the levels of goods and services that have been expended by the hospital on behalf of the patient.

ICD-10 and Patient Financial Services

Impact of ICD-10

The **PFS** department will be responsible for **testing the new electronic 5010 electronic billing system** with ICD-10 codes.

PFS, in dealing with the payer mix, must **assess the level of support each payer will provide for the ICD-10 transition**. Some payers plan to map the codes from ICD-9 to ICD-10, while others are going to completely transform their systems to ICD-10 readiness. This will create a difference in how ICD-10 codes are interpreted by each payer.

Processes in PFS add a number of days to the DNFB with ICD-9, so staff in this department will need a **very good foundation in ICD-10** in order to continue productivity levels and mitigate some of the delays that will inevitably occur.

Transitioning to ICD-10-CM

So, what are the next steps?

Education is the key for a successful ICD-10 transition and different levels of training will be needed based on your job role and the impact of ICD-10-CM on that role.

The most important fact to remember is that ICD-10-CM ushers in a new era of required specificity in the medical record, demanding broader understanding of how ICD-10 impacts each job responsibility and healthcare process.

Questions?

- **Contact Information:**

    Nena Scott, MSEd, RHIA, CCS, CCS-P

    AHIMA ICD-10-CM/PCS, Certified Trainer

    nscott@precysesolutions.com

    662-205-4178