ICD-10 Implementation for Physicians

Presented by:

PRACTICE® MANAGEMENT INSTITUTE

Background

- Developed by the World Health Organization in 1993, the International Classification of Diseases (ICD) is a medically-based code system used by health care professionals to document information in the health record that communicates detailed information crucial for health care management, billing and general health system administration.
- ICD codes serve as a universal language that provides accuracy and consistency in health records worldwide, which ultimately ensures that quality of care and sound management of health systems resources.
- This calls for accurate and consistent use of clinical terminologies and the importance of interoperability.

ICD-10

- ICD-9-CM was established in 1978 and is presently used by U.S. providers to document diagnoses. The code set is divided into two indexes, with Volume 1 representing the tabular index of diagnosis codes and Volume 2 representing the alphabetical index of diagnostic codes. There is a third volume consisting of institutional procedure codes but these are used only in inpatient hospital settings.
- The U.S. continues to use ICD-9 codes while most of the world has already moved to the more detailed ICD-10 codes. Limitations of ICD-9 system include outdated terminology that is inconsistent with current medical practice. Lacking in several areas critical for accurate diagnoses, the “9” codes do not provide the level of detail necessary to further improve accuracy and streamline automated claim processing.

ICD-10

- After years of speculation and planning the United States has finally committed to moving from the International Classification of Diseases, Ninth revision to the next level known as ICD-10. With this change will come significant growing pains and physicians as their staffs learn the new, more detailed code set required to complete the billing process for services rendered.
- The deadline to complete the conversion is set for October 1, 2015. Making this transition is not optional and all third-party billing is impacted. Billing submitted for payment without proper codes will be rejected, not only by Medicare, but by almost all third-party carriers.

ICD-10

- Moving to the ICD-10 system will result in fewer payer-physician inquiries and potential claim payment delays or inappropriate denials. CMS has documented many benefits to the transition, most pointedly, improved operational capabilities and processing, including:
- Detailed health reporting and analytics: cost, utilization, and outcomes;
- Detailed information on condition, severity, comorbidities, complications, and location;
- Expanded coding flexibility by increasing code length to seven characters utilizing both letters and numbers; and
- Improved operational processes across health care industry by classifying detail within codes to accurately process payments and reimbursements.

Impact to Physicians: Getting the Facts Straight

- Moving to ICD-10 means the number of codes used to document a diagnosis will increase from about 14,000 possible 3-5 character codes in the ICD-9 to 68,000 3-7 character codes in ICD-10. Providers will need to communicate with their coders/billers on a much more detailed level in order to receive payment for their services. This change has been met with considerable resistance due to mounting costs, staff training and the daunting task of restructuring documentation, coding procedures, as well as systems and processes.
- **Myth:** A common misconception among physician offices is that they think the conversion to ICD-10 is only going to impact physicians that serve Medicare /Medicaid beneficiaries.
- ***Fact:*** *All HIPAA-covered entities must implement the new code sets with dates of service, or date of discharge for inpatients, that occur on or after October 1, 2015, regardless of specialty or participation in a government-funded health care program. Non-covered entities, which are not covered by HIPAA such as Workers' Compensation and auto insurance companies, that use International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) may choose not to implement ICD-10-CM/PCS. Because ICD-9-CM will no longer be maintained after ICD-10-CM/PCS is implemented, it is in non-covered entities' best interest to use the new coding system. The increased detail in*
- *ICD-10-CM/PCS is of significant value to non-covered entities. The Centers for Medicare & Medicaid Services (CMS) will work with non-covered entities to encourage their use of ICD-10-CM/PCS.*

Myth: Health care operations that have completed the transition from paper-based to electronic-based health records management systems with 5010 electronic submission compliance have taken steps in the right direction. However, relying on an EHR system to complete crossover will not be sufficient.

- ***Fact:*** *While some EHRs have tools in place to help crosswalk some codes, offices must have well-trained coders, proficient in medical terminology and anatomy and physiology, to crosscheck code entries to ensure their accuracy. While the EHR is a great tool to provide efficiencies within the office, a coding professional must still verify that codes support clinical documentation accurately before submitting for payment.*

- Many providers are operating with blinders on, especially those who don't interface with hospitals. Still others think that someone else will handle the upgrade to billing procedures. Others may think the conversion requires a few procedural upgrades, completely unaware of the magnitude of the conversion and potential train wreck ahead for their reimbursement.
- ***Fact:*** *Without buy-in from the top, the conversion will be an arduous process for their organization. Failure to educate oneself about changes in health care will not insulate the office from the conversion. It will only further delay much-needed staff training that needs to take place well before the deadline.*

With just a year remaining to complete the transition, providers and their staff must step up to planning, training, software/system upgrades/replacements, as well as other necessary investments.

6 Stages of ICD-10 Implementation

- Planning
- Communication and Awareness
- Assessment
- Operational Implementation
- Testing
- Transition

Phase 1 – Planning

During the planning phase, providers should establish a project management structure and governance, plan to communicate with external partners, and establish risk management.

At a minimum, the provider should consider the following activities:

- Ensure top leadership understands the breadth and significance of the ICD-10 change.
- Assign overall responsibility and decision-making authority for managing the transition.
- Plan a comprehensive and realistic budget.
- Ensure involvement and commitment of all internal and external stakeholders.
- Adhere to a well-defined timeline that makes sense for your organization.

Implementation Timeline

Using an ICD-10 Implementation Timeline as a guide, the office should:

- Identify any additional tasks based on specific business processes, systems, and policies.
- Identify critical dependencies and predecessors.
- Identify resources and task owners.
- Estimate start dates and end dates.
- Identify entry and exit criteria between phases.
- Continue to update the plan throughout ICD-10 implementation and afterwards.

Phase 2 – Communication and Awareness

A communication and awareness plan ensures that all internal and external stakeholders—that is, staff and all affected entities that the office does business with understand their responsibilities for ICD-10 implementation. During this phase, the implementation team should create a communication plan, assess the training needs of the office and develop a training plan, as well as meet with staff to discuss the effect of ICD-10 and identify implementation responsibilities.

The communication plan should identify:

- Stakeholders
- Audiences
- Messages
- Issues
- Action triggers
- Roles and responsibilities
- Timelines
- Communication methods
- Evaluation techniques

Note: The size of the office will determine how much planning and documentation will be necessary.

Phase 3 – Assessment

The conversion to ICD-10 will affect how the office handles many processes, from check-in and scheduling to referrals. During the assessment phase, common business processes and functions are evaluated to determine the effect that the transition to ICD-10 will have on the facility.

The assessment should include the following areas:

- Operations
- Financial Impact
- Documentation Changes
- Technology

Phase 4 – Operational Implementation

Once assessment and planning are complete, the next step is to determine what changes need to be made to operations and systems in order to limit business risks and take advantage of opportunities.

Most organizations depend on their vendors to provide support for the ICD-10 transition. Providers, however, should not assume that vendors would address the effects of the ICD-10 implementation on key functional areas, including:

- Patient registration
- Clinical documentation/health records
- Referrals and authorization
- Coding
- Order entry
- Billing
- Reporting and analysis
- Other diagnosis-related functions, depending on the nature of the practice

ICD-10

Provider offices should verify that vendors are prepared to meet critical ICD-10 transition needs.

During this phase, provider offices should:

- Identify system migration strategies
- Implement business and technical modifications
- Prepare and deliver training
- Determine if/how the practice will work with vendors for implementation
- Coordinate with vendors - the update of internal processes affected by ICD-10, including clinical, financial, actuarial, and reporting functions
- Finalize system/technical requirements
- Identify test data requirements
- Update approved code design to remediate system changes and updates
- Coordinate update of code with vendor to remediate system changes/updates

Phase 5 – Testing

During this phase of implementation the office should develop a testing strategy that includes both complete Level I – Internal Testing and Level II – External Testing. Providers should coordinate and conduct testing with partners with the updated systems.

Testing plan should include the following:

- Develop a project plan that recognizes dependencies on tasks and resources. The plan should prioritize and sequence efforts to support critical paths.
- Talk with vendors about system upgrades, costs involves, when testing and implementation will take place and what type of support will be provided.
- Identify testing workflows and scenarios that apply use cases, test cases, test reports, and test data.
- Identify when test claims can be run using ICD-10.

Phase 6 – Transition

During the transition period, the office should monitor the impact of ICD-10 on practice operations and revenue. Production and go-live steps should be established along with ongoing support and preparation for corrective action.

For more implementation guidance, click the link below to review the informative guide prepared by CMS:

ICD-10 Implementation Guide for Small and Medium Practices

Education and Training

To prepare for ICD-10, physician offices will need to identify available resources, determine training needs, build a training plan and manage productivity during the transition process. The training plan's purpose is to ensure that staff and external partners acquire the necessary skills and knowledge of the processes, procedures, policies, and system updates particular to the organization's ICD-10 implementation.

Decide on how much training is needed and determine the costs. To do this, offices will need to determine who will be trained and how, as well as the number of hours of education that will be required. Include the costs for additional chart audits to make sure the documentation will support diagnosis coding for ICD-10. Consider lost revenue if physicians and non-physician practitioners need to be out of the office for training—not to mention that productivity might be affected. When looking at training costs, the administrators must determine the extent of training each department and/or staff person needs. As a rule, physicians, non-physician practitioners, coders, and billing staff will need more extensive training than ancillary staff (e.g., nurses, MAs, managers, etc.).

Developing Training Plans

The first step for clinical and administrative staff would be learning enough about the new coding system to understand what the differences in the code sets are, and what specific impacts it will have on the office. As this is not a simple substitution of one code for another, the learning curve is expected to be quite steep for both clinicians and their administrative staff.

This issue will be especially acute in small to medium sized offices that do not employ certified coders. Because ICD-10 codes are much more specific than ICD-9, all of individuals using the codes will need specialized training to understand the more specific codes. Detailed training in documentation of patient activities, coding of medical records and administrative records, information technology, health plan relations, and contracts will be necessary. In addition, learned patterns and relationships among codes would have to be relearned because of the changed structure and organization of the code set.

Regardless of the size of the practice, training for any implementation – especially for one as complex and far reaching as ICD-10, can be costly and difficult to deliver. While large organizations may have the resources to purchase training materials or send staff to training sessions, smaller organizations may have to depend on special societies or share resources to provide the needed training. ICD-10 will require a significant education investment in order to ensure accurate coding and minimize productivity loss. If codes are not correct by the deadline, reimbursements will be significantly delayed or dropped.

If not completed during the assessment stage, the first step in developing an effective ICD-10 training plan is to assess current internal IT, coding, and software training staff, their capabilities, and bandwidth to take on the significant training required for ICD-10. There are wide varieties of complementary external training options specific to ICD-10 such as conferences, webinars and online training, super user training, and contracted onsite training.

Clinical Documentation Training for ICD-10

ICD-10-CM includes a fuller definition of severity, comorbidities, complications, sequelae, manifestations, causes, and a variety of other important parameters that characterize the patient's condition.

As a result, ICD-10 will require more detailed documentation than currently necessary for ICD-9, and providers are going to have to pay even closer attention to their documentation. For example, diabetes coding in ICD-9 requires providers to document at least the type and control status. In ICD-10, however, providers will still need to document the type, but not necessarily whether it is controlled; this information is not a routine part of the ICD-10-CM code as it was in ICD-9. Yet many diabetes codes in ICD-10 also include combination codes identifying both manifestations and underlying condition. Example:

E08.21 Diabetes mellitus due to underlying condition with diabetic nephropathy (combination code)

Developing a training strategy that serves clinical education needs for improved information accuracy is critical to successful ICD-10 implementation. Feel free to edit as needed. I just wasn't sure about the original example used because it actually made documentation for diabetes seem less specific.

Assessing Staff Training Needs

- Not all coding staff will require the same type or amount of ICD-10 education. Training for coding staff that work for the healthcare organization's medical specialty area or specialty clinic should focus on the code categories most applicable to the particular patient mix.
- Engage providers and work with them to improve their documentation as well as responding to coding queries.
- Estimates indicate that coding staff working in the outpatient setting will require 16 hours of ICD-10 education. This training should focus on ICD-10-CM and not ICD-10-PCS.
- Determine staff competence and skill gaps, and how to tailor trainings to individuals or business user groups.
- All coding staff should complete their full ICD-10 education no more than six to nine months before the compliance date to make sure the information is retained.
- Consider best approach training methods for your practice, including webinars, certification courses, onsite training and community courses. If you have a small practice, think about teaming up with other local providers.

- Using a practice self-assessment questionnaire may help identify factors that will dictate the appropriate training needs.
- Use training aids to ensure training concepts are incorporated into work practices.
- Include testing as a part of certain training; set minimum score thresholds.
- Assess the staff for ICD-10 proficiency after training and provide additional training to address weaknesses. To do this, identify common inaccurate code decision-making, clinical documentation errors, and productivity lags.
- To address proficiency issues, identify needs to assist with frequently asked questions about coding, category quick reference sheets, system user prompts, or refresher courses.
- Continue training well into the post-implementation phase.
- Utilize evaluation tools to solicit feedback on the effectiveness of the training.

TRAINING SELF-ASSESSMENT QUESTIONNAIRE

Who must receive training on the ICD-10 code set? Especially in small and medium-sized practices, training will be required for all clinical and administrative staff. Topics include documenting patient activities, coding medical and administrative records, information technology, health plan relations and contracts

How will you customize training for the right roles?

- Management
- Information technology
- Clinical care and documentation
- Operations and billing
- Coding and record management
- Compliance
- Finance
- Quality management

What options are available to train staff (e.g., onsite, vendor training, community courses, webinars, and certification courses)?

Does the staff have a thorough knowledge of medical procedures and anatomy for coding purposes?
Identify opportunities for staff to receive certification in ICD-10 coding to minimize inaccuracy and build “ICD-10 know-how” throughout the practice

By what date should staff complete any needed training?

How long will it take to train the staff?

Which training format(s) will work best for the staff (for example, classroom training, web-based training, or self-guided materials)?

How much will the training cost?

What resources will staff need after training to answer questions and resolve problems as they come up (for example, manuals, system prompts, troubleshooting guides, or FAQs lists)?

How will staff maintain operations during the training process?

- Decide whether there is a business need for additional experienced coding staff to support the ICD-10 transition period.
- Consider outsourcing additional coding expertise during the preparatory stage, which will allow for just-in-time training and reduce the burden of the transition on staff.
- Review current staffing levels and determine need for hiring additional staff or outsourcing .

How will you determine the effectiveness of your training?

- Testing
- Quality monitoring
- Feedback methods
- Incentive development

Training Topics, Purpose and Audience

Training Topic	Purpose of Training	Audience
Basic understanding of the ICD-10 code set and implementation	• Understand the differences between ICD-9 and ICD-10 • Understand rationale for ICD-10 adoption • Understand existing tools, risks, and industry updates • Clarify roles and responsibilities	Physicians, nurse practitioners, physician assistants, clinical technicians, clinical researchers, administrative staff, coders, and vendors
Basic concepts of anatomy and pathophysiology relevant to ICD-10	• Understand basic concepts of anatomy that are relevant to ICD-10 and patient care • Understand basic concepts of disease processes and patterns that are relevant to ICD-10 and patient care	Physicians, nurse practitioners, physician assistants, clinical technicians, clinical research, administrative staff, coders, and vendors
ICD-10 coding	• Review ICD-10 coding knowledge of medical procedures and anatomy including clinical specificity of the new code sets • Refresh anatomy knowledge, if needed	Coders and administrative staff
ICD-10 effects of clinical documentation on both proper coding and good patient care	• Describe how documentation and coding impacts business processes • Describe clinical documentation needed to support good patient care and simultaneously support proper coding in ICD-10	Physicians, nurse practitioners, physician assistants, clinical technicians, finance, physician practice staff, compliance, administrative staff, coders, and vendors
Partner and contractor	• Explain roles and responsibilities in ICD-10 implementation process	Partners and contractors
Using systems updated for ICD-10	• Review how ICD-10 affects systems • Review system updates • Develop a roadmap for leveraging the advantages of ICD-10 both from the clinical and business perspective	IT staff, clinicians, practice staff, and compliance

Finding a Qualified Training Provider

When it comes to the staged ICD-10 implementation, many offices have just begun to scratch the surface. Training is an integral piece of the transition pie. Providers and their staffs should participate in training developed in accordance with CMS staged implementation. Practice Management Institute® has a series of classes designed specifically for physician offices. PMI courses are taught in leading hospitals and health care systems. Classes are designed to reinforce and build on the participant's existing body of knowledge, providing better overall comprehension and retention. These classes prepare coders/third party billers, and managers for a successful transition.

For example, classes for coders will include terminology instruction focused on:

- Identifying specific conditions, key concepts, key words to glean the information necessary to properly code from a medical record
- Following crosswalks illustrating differences from ICD-9 to ICD-10
- Determining what in a medical record is and is not relevant to the coding scenario
- Hands-on scenarios and coding examples will put knowledge into motion to improve ICD-10 coding comprehension and retention.

Practice Management Institute is already helping practices adapt to the change. ICD-10 coding and implementation are taking place in hospitals across the country. As the conversion process continues to move forward, Practice Management Institute will continue to provide the most up-to-date information on implementation guidelines, coding conversion steps and staff training fulfillment.

- *"With the significant changes occurring with ICD-10, we felt that it was extremely important to inform and educate our medical staff regarding how ICD-10 impacts them and how best to prepare for its implementation. We looked to Practice Management Institute and MedChi for a CME program for our physicians because of PMI's leadership in practice management programs for medical professionals. Physicians and other medical personnel who attended this program were very pleased with both the quality and content of PMI's CME offering."*

  Dennis Nordquest

  Manager, Physician Relations

  Akron General Health System

For more information on PMI's CME-approved ICD-10 training for physician offices, visit www.pmiMD.com.

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