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From Medscape Education Family Medicine: Transition to ICD-10: Getting Started.
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Target Audience: This activity is intended for all healthcare providers who are interested in or will be involved in planning for and/or using ICD-10 codes.

Goal: The goal of this activity is to assist practitioners and healthcare organizations in starting the process of transitioning to the use of ICD-10.

Learning Objectives: Upon completion of this activity, participants will be able to:

- Outline how individual clinicians can start getting ready for transitioning to the use of ICD-10
- Identify resources that can serve to guide individuals and organizations in the transition to ICD-10

Introduction

The International Classification of Diseases, 10th Revision (ICD-10) represents a major change in how healthcare information will be collected, documented, and ultimately used, both in the United States and worldwide. In fact, ICD-10 has been used in many countries around the world for several years. The expanded ICD-10 list of codes for conditions and procedures provides a much more specific picture of the physician-patient encounter than can currently be captured with ICD-9. Moreover, ICD-10 will play an essential role in everything related to the practice of medicine, from how claims are processed and paid to analytics, research, and quality measures.

All practices can make a successful transition to ICD-10, but to do so they need to start planning now -- and physicians themselves must become engaged in the process. They must be educated about the facts of ICD-10, its implications, and what their responsibilities are in the transition. This article, based on a conversation with Dr Joseph Nichols, an orthopedic surgeon and principal, Health Data Consulting, Seattle, Washington, provides some valuable information to help physician practices begin the transition process.

Implementing ICD-10

Implementation of ICD-10 will vary a great deal by the size and type of organization. The larger healthcare providers -- eg, hospitals, hospital-based systems, and even clinic provider organizations -- have more sophisticated systems that need to be remediated and more work that needs to be done than smaller practices, but they also have a greater number of resources, including administrative personnel. Smaller practices may face more challenges in obtaining the information or resources they need, but they will also, at least to some degree, have less work to do than the larger organizations. Regardless of their size, the bottom line for all organizations is that all providers need to start planning now.

1. Improve Documentation Now

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A very clear focus on better documentation is absolutely critical to the success of ICD-10 -- and to good patient care. The codes will affect so many facets of health care downstream, ranging from quality measures to analytics, research, payment, and surveillance, that they must be as accurate as possible, and accurate coding cannot be achieved without the physician's efforts to provide good documentation. As such, there is no reason to delay implementation of good documentation practices. All of the information that is required to code according to ICD-10 is information that is necessary to an individual patient's care and is already documented in the medical record. Therefore, the primary focus for all physicians now is to identify what is included in the documentation and make an assessment of their current practices. Address questions like: "What are you documenting today?" "Are there ways you can more appropriately document?" "How can you ensure that you document accurately for ICD-10 and for good patient care?" Failure to fully and properly document a patient encounter has many medical, financial, and even regulatory ramifications, but will also significantly impede progress in moving to ICD-10.

2. Develop the Relationship Between Coders and Clinicians

Clinicians do not need to understand all of the intricacies of coding, and coders do not need to understand all of medicine -- but the 2 must work together to ensure optimal accuracy.

The relationship between clinicians and coding professionals will have to evolve for ICD-10 to run smoothly. Clinicians do not need to understand all of the intricacies of coding, and coders do not need to understand all of medicine -- but the 2 must work together to ensure optimal accuracy. As discussed, clinicians must accurately, precisely, and comprehensively document the patient's health state and/or procedures performed. For their part, coders need to understand basic anatomy and pathophysiology to better understand the provider's documentation. There will be an inevitable increase in questions from coders, at least until everyone is accustomed to the new codes and system. Anything that practices and providers can do to improve and facilitate the working relationship between clinicians and coders will contribute to a smoother transition. Ultimately, practices want to encourage clear documentation by clinicians and accurate coding by coders.

3. Institute Strategies for Training

There is no one-size-fits-all training for ICD-10, which really has to occur at multiple levels. The first step, though, is for leadership, those individuals who are responsible for moving things through the organization, to understand what the impact of ICD-10 will be, what challenges can be anticipated, and what the necessary steps are to implement the changes. Leadership needs to make sure that hospital executives and senior physicians within large and small practices are aware of the changes, that they support the planned changes, and that the organization is able to move to the next step.

Training for personnel further down the line should take place closer to the implementation date. Coders, for example, should have training about 6 months (and no more than a year) before the implementation date. Still, the timing is variable. One strategy involves parallel coding, which means taking the same cases and coding them according to ICD-9 and ICD-10 for up to a year prior to implementation. This approach allows for parallel training and testing. By coding the

same condition in ICD-9 and ICD-10, providers can work with their payers to identify any issues related to payment in ICD-10 -- before the point that cash flow might be substantially affected. It should be noted, however, that ICD-10 codes will not be accepted for payment (outside of testing scenarios) before the implementation date.

Although the timing for training will vary by organization, leadership should get started. They should understand enough about the coding changes to be able to understand what the implications are for documentation and business practices.

4. Locate the Resources for Help

The Process

Numerous resources have been developed and are available to help in implementing ICD-10; the key is for providers to take advantage of them. Official resources are available at the Centers for Medicare & Medicaid Services (CMS) ICD-10 website. The site, which is well vetted, provides good background and perspective, has a number of free papers to help in implementation, and includes all the official codes and guidelines. Implementation guides for both small and large practices are available that walk the user through the process. Indeed, much of the information available at other sites is derived from the CMS site.

Training

There are 2 major, well-respected, accredited societies that offer training for coders: the American Association of Professional Coders (AAPC) and the American Health Information Management Association (AHIMA). In addition to providing formal training for coders, these organizations also provide training for trainers, as well as those who assist in the management of business operations and information technology.

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Currently, the AAPC offers training for clinicians on documentation, highlighting what they need to document and why it is important. The AAPC is also working with coding professionals to show them how to better interpret what is written in the medical record in a way that is understandable, clear, and consistent with what they are coding. Professional organizations, such as the AAPC and AHIMA, are actively working to help clinicians and coding professionals improve their respective abilities to take what actually happens during a patient encounter and convert it into a code.

Other helpful resources include the Healthcare Information Management Systems Society (HIMSS) and the Workgroup for Electronic Data Interchange (WEDI).

Relationships: Working Together to Institute Changes

The transition to ICD-10 must be made across the healthcare sector, from clinician practices to the parties they work with, including vendors and payers. It is therefore critically important for practices to ensure not only that they are accurately making necessary changes but that those

they work with are also making the transition. By creating common scenarios and virtually testing these scenarios (both internally and with external trading partners) using ICD-10, it is possible to evaluate readiness and potential challenges moving forward. It is very important to continue to test as the changes are being implemented to identify any potential pitfalls and know how to respond to them before the system is live.

1. Vendors

In general, most physicians and other healthcare providers rely on their vendors not only to help them get to the right code but also to use those codes appropriately for billing, reporting, analysis, and a variety of other business purposes. Practices therefore will be adversely affected if vendors are not ready with or have not fully included ICD-10 in their products. As such, it is important for physicians and other providers to ask their vendors whether they will be ready (the answer will generally be yes) and to also have them demonstrate their readiness. Vendors should be asked to demonstrate what they will do when ICD-10 is in effect.

2. Payers

Both payers and providers have a large stake in ensuring that the other is properly prepared for implementation. Providers are responsible for understanding how to code, and the payer should know how to process the claim. The only way to ensure that both parties will properly enact the required changes is to create test environments. Payers and providers should work together to identify some of the most common reasons for patient visits, and then identify how conditions and/or procedures would be coded and processed in ICD-10.

Search Tools

One of the major on-the-ground changes wrought by ICD-10 is related to the need to search for codes. With the increased number (about 5 times as many) and the different structure of the codes (there are now many combination codes, which means that 1 code can have a lot of information packed in it), it could be confusing or time-consuming to find the appropriate code. Moreover, all related diseases do not always appear in 1 particular bucket. For example, let's look at the codes related to pneumonia: While there may be a set of 14 codes in the chapter of the ICD-10 code book related to pneumonia, pneumonia also appears in many other areas of the book. Pneumonia related to staphylococcal infection is actually listed in the section under *Staphylococcus,* while pneumonia related to other conditions may be listed in different sections associated with those other conditions. Similarly, hypertension associated with diabetes might be in the diabetes section, whereas hypertension associated with kidney disease might be in the renal section. Depending on how many different types of diagnoses the clinician usually deals with, the use of a good search tool could be essential to the smooth and timely identification of the proper code.

Finding a good search tool, however, can pose a real challenge because there is no "best" one that fulfills all clinicians' needs. A fair amount of investigation will be required to evaluate the available tools, and it should be noted that cost is not necessarily the deciding factor. Some of the less expensive tools may do a better job than some of the very expensive tools. The best way to evaluate a tool is to conduct some tests. The most frequently encountered conditions and procedures can actually be tested with the tools to determine whether the tool identifies the

appropriate codes. Some tools will return all the codes related to the condition, regardless of what chapter it is in, while others will identify a limited set of codes because they simply go to the specific chapter. It is highly variable; staff and clinicians should take the time to find the one best suited for their practice.

Simple Advice: Start Planning Now

The transition to ICD-10 represents a significant change and a potential disruption in business as usual. The key to a smooth transition and minimal disruption lies in preparation. Clinicians can begin now by improving their documentation and their channels for communicating with coders. Providers in large practices should bring their leadership together to begin planning. There are many groups, sites, and organizations that are eager and willing to help.

Resources

Centers for Medicare & Medicaid Services (CMS) ICD-10
American Association of Professional Coders (AAPC)
American Health Information Management Association (AHIMA)
General Equivalence Mappings (GEMs)
Healthcare Information Management Systems Society (HIMSS)
The Workgroup for Electronic Data Interchange (WEDI)
World Health Organization. International Classification of Diseases (ICD)

Abbreviations

AAPC = American Association of Professional Coders
AHIMA = American Health Information Management Association
CMS = Centers for Medicare & Medicaid Services
HIMSS = Healthcare Information Management Systems Society
ICD-10 = *International Classification of Diseases, 10th Revision*
WEDI = Workgroup for Electronic Data Interchange

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