ICD-10 *The Physician Role in Better Health Information*

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Editors' Note: Though efforts continue via the AMA to delay or discontinue the implementation of ICD-10, the OMA will continue to work to prepare Oregon physicians and PAs for implementation in 2014. 2013 workshop details are on page 7.

ICD-10 REPRESENTS ONE OF the most significant changes to health care information in decades. The ICD code set is the only nationally mandated standard for the definition of the patient's health condition and the institutional procedures done to maintain or improve that condition. These codes are used for a variety of purposes important to health care including:

- Population based research
- Disease trending and surveillance
- Claims payment
- Quality and effectiveness measures
- Assessment of fraud waste and abuse
- Claims policy development and administration
- Coverage determination
- Patient history

Proper coding is critical to assure that these important activities can be accomplished with integrity.

What's Different?

- **More codes**—There are nearly five times more codes in the ICD-10 diagnostic code set than the ICD-9 set.
- **Substantially more detail**—The biggest change is the ability to define conditions with much greater specificity related to severity, risk, co-morbidities, complications, manifestations and other key parameters of the patient health condition.
- **Combination codes**—ICD-10 codes tend to combine a great deal of information into a single code. For example:

  S52571M—Other intra-articular fracture of lower end of right radius, subsequent encounter for open fracture type I or II with nonunion

  In this example, there are a number of key medical concepts defined within a single code. In ICD-9, "non-union" would be defined in a single separate code, but in ICD-10 the concept of non-union is combined in approximately 3000 fracture related codes.

What's The Same?

- Most of the guidelines and definitions are the same.
- The structure of the documentation for diagnostic coding is similar to ICD-9.
- Requirements to use the most specific code appropriate to the patient are the same.
- Requirements related to clinical documentation to support coding are the same; as codes are more detailed, sufficient document detail is needed.

Why So Many Codes?

Many are concerned about the number of codes and apparent complexity of the code set. However, there are relatively consistent repeating patterns so that identification of the proper documentation requirements is simpler. For example, there are over 1800 codes for fractures of the radius, but only approximately 50 distinct medical concepts in this code set, any of which may be important to document depending on the nature of the patient's specific condition.

One third of the codes are only different in the description of right vs. left. For every fracture there is a code for initial encounter, subsequent encounter or sequel. For every fracture seen in follow up, there is a code for normal healing, delayed healing, non-union or mal-union. These repeating patterns result in many multiples of codes that are otherwise the same. Learning these basic patterns and including needed documentation makes coding much simpler. Even today while we have nearly 15,000 codes, 5% of the codes account for over 70% of the volume of codes used. We have codes like "hit by a spacecraft" or "suicide by paintball" in ICD-9 today, but a typical practice may only use a small set of codes. The key is to make sure that the codes accurately represent the patient condition, and key parameters of the patient condition are consistently documented.

The Clinician Role

The primary role of the clinician in coding and health information is to make sure proper documentation exists to support patient care across the continuum. While some documentation requirements have been viewed as burdensome, in nearly all cases, analysis shows they are important to support good patient care.

While the clinician may not want to take on the role of an expert coder, only the clinician can assess the patient and document findings appropriately to allow proper coding. Coders rely on clinicians to document accurately and clinicians may rely on coders to assure that important data transactions represent the patient condition accurately.

Moving Into A New Environment

The health care environment is going through a major informational change driven by standard data shared across health care entities. There is a strong drive toward cost-controlled, value-based, accountable care. Clinicians must take a leadership role in assuring that health care information accurately represents what's done to care for patients and why. As providers take on more financial risk for care, it will be important to manage that risk with reliable data about their patient population.

While ICD-10 may seem to represent an unnecessary burden, a closer look at the code set and how it is used will hopefully convince them that most of what is required is really about good patient care and better information to improve health care delivery for the population. ■