ICD-10 Implementation Hurdles

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Agenda

• Course Objectives
  – Performing a gap analysis
  – Developing a business plan for ICD-10 implementation
  – What to expect during the implementation process
  – Clinical documentation issues in ICD-10
ICD-10-CM Changes

• There are multiple changes in store for coders such as:
  – the addition of information relevant to ambulatory and managed care encounters
  – expanded injury codes in which ICD-10-CM groups injuries by site of the injury, as opposed to grouping in ICD-9-CM by type of injury or type of wound
  – creation of combination diagnosis/symptom codes, which reduces the number of codes needed to fully describe a condition
  – greater specificity in code assignment (up to seven characters)
  – V and E codes being incorporated into the main classification in ICD-10-CM
  – ICD-10-CM codes being alphanumeric and including all letters except U
  – the length of codes in ICD-10-CM being a maximum of seven characters, as opposed to five digits in ICD-9-CM

Format of ICD-10-CM

• *The Tenth Revision (ICD-10) differs from the Ninth Revision (ICD-9) in a number of respects, although the overall content is similar*
  – ICD-10 is printed in a three-volume set compared with ICD-9 two-volume set
  – ICD-10 has alphanumeric categories rather than numeric categories
  – Some chapters have been rearranged
  – Some titles have changed
  – Conditions have been regrouped
  – ICD-10 has almost twice as many categories as ICD-9
  – Minor changes have been made in the coding rules for mortality
Performing a Gap Analysis

Process Improvement

• Every practice could benefit from improving processes in the medical office.
  – Often processes and improvement due to time pressure.
  – Every staff person in the practice is too busy to review the process and make change.
  – Change is sometimes not welcomed and can be painful.
Process Improvement

• Policy change development should begin soon after analyzing business processes and the development of a Gap Analysis.

• When the practice determines what business area processes need to be changed, it can be accomplished in stages instead of all at once if the organization begins the process quickly.

Process Improvement

• For example:
  – based on the evaluation of the business processes and Gap Analysis, ABC Medical Group decides that reviewing all medical policies and auditing clinical documentation using ICD-10-CM is a top priority and one of the deficiencies currently evident based on the analysis.
  – The practice should develop a comprehensive plan for improvement in these two areas.
Policy Changes

• While all changes do not lead to improvement, all improvement requires change.
• The ability to develop, test, and implement change is essential for any individual, group, or facility that wants to continuously improve.

Change Concept

• Plan
• Do
• Study
• Act
Developing a Business Plan

Using a Business Case to Finalize the Impact Analysis

- Formal document that describes the business reason
- A typical ICD-10 business case describes
  - the business problem
  - the possible solutions
  - the risks and benefits of each course of action
  - the solution recommended
Why is a Business Case Useful?

• The business case helps communicate the objectives of the project, and provides the information necessary to move to producing business requirements.
• The business case allows decision makers to determine their level of risk tolerance, and establishes a realistic expectation of the amount of risk associated with the approved project.

Analyzing the Business Processes

• One there is a general understanding of ICD-10-CM/PCS, an analysis should be conducted of how ICD-10-CM/PCS will impact the organizations business process.
• It is estimated this process will most likely take three to four months at minimum to complete.
Business Processes Affected

- Clinical (e.g. Laboratory, Radiology, documentation, medical policy, etc)
- Administrative (e.g. Practice Management and Registration)
- Billing (e.g. Computerized systems and Superbills)
- Other (e.g. Quality and Public Health)

The Clinical and Business Impact

- The clinical area of the medical practice will be affected with ICD-10-CM implementation.
- The administrative area will be affected in relation to information technology, coding, billing, training, financial and staffing.
Medical Contracts and Policies

• One of the most significant impacts to the clinical area is the impact of ICD-10-CM to health plan contracts and medical policies.

Medical Contracts and Policies

• **Steps when analyzing this impact include:**
  – Identify contracts where reimbursement is tied to particular diagnoses
  – Contact payers and discuss potential changes to existing contracts
  – Determine timing of contract negotiations
  – Modify agreements as needed
  – Communicate contract changes to appropriate staff
Insurance Plan Contracts

• Participation in health plans should be reviewed — as with the medical policy changes the organization may end the association with a particular plan and may participate in other health plans not yet contracted with.
  – A complete and thorough review of individual health plan contract changes should be undertaken as part of the analysis to determine what health plans the organization will contract with after ICD-10-CM is implemented.

The Patient

• The patient may also be affected by the transition to ICD-10-CM.
  – Insurance coverage determinations should be reviewed based on ICD-10-CM.
  – Treatment decisions a provider makes may be driven by coverage policies because they are changed to reflect the level of specificity in ICD-10-CM.
  – Practices may have to develop written material that assists in explaining what changes have been made, why they were made, and also what changes patients may see in their explanation of benefits from health plans.
Documentation

• The level of detail required in medical documentation for assignment of ICD-10-CM codes will require in most cases additional information to code the service and treatment plan.
• To move readiness forward, identify current documentation deficiencies when reporting diagnoses in the medical record.

Documentation Impact to Implementation

• If the physician or provider is not documenting currently to the level of specificity to report the clinical condition, the increased documentation requirements will increase the amount of time and effort the organization spends on each patient encounter
  – This will decrease productivity due to not only learning the new code set, but learning documentation requirements for the codes.
  – This might even decrease the number of patients a medical practice could treat per day — which does have an impact on the organization’s financial health.
Example

- Acute otitis media
  - The diagnosis code reported in ICD-9-CM would be unspecified (381.00-unspecified acute nonsuppurative otitis media).
  - However, in ICD-10-CM the diagnosis of acute otitis media (H65.1-other acute nonsuppurative otitis media) cannot be coded without additional information such as what ear is affected, and identifying if the problem is initial or recurrent.
    - Patient has an acute onset of otitis media of the right ear, which is recurrent.
    - In ICD-10-CM this is report with H65.114 (Acute and subacute otitis media recurrent, right ear).

Clinical Documentation Issues

- Going from 14,000 codes to over 69,000
  - Requires greater specificity
  - Laterality
  - Stages of healing
  - Trimesters in pregnancy
  - Depression
Laterality

- ICD-10-CM code descriptions include right or left designation
  - Right side is always character 1
  - Left side character 2
  - Bilateral character 3
  - Unspecified side is either a character 0 or 9, depending on whether it is a fifth or sixth character

Laterality Example

- M12.15 Kaschin-Beck disease hip
- M12.151 Kaschin-Beck disease, right hip
- M12.152 Kaschin-Beck disease, left hip
- M12.159 Kaschin-Beck disease, unspecified hip
Diabetes mellitus

• The biggest change in the guidelines from ICD-9-CM to ICD-10-CM is coding for Diabetes Mellitus.
• There are six (6) Diabetes Mellitus categories in the ICD-10-CM. They are:
  • E08 Diabetes Mellitus due to an underlying condition
  • E09 Drug or chemical induced diabetes mellitus
  • E10 Type I diabetes mellitus
  • E11 Type 2 diabetes mellitus
  • E13 Other specified diabetes mellitus
  • E14 Unspecified diabetes mellitus

Type of diabetes

• The age of a patient is not the sole determining factor, although most type 1 diabetics develop the condition before reaching puberty.
  – For this reason type 1 diabetes mellitus is also referred to as juvenile diabetes.
Diabetes mellitus and the use of insulin

• If the documentation in a medical record does not indicate the type of diabetes but does indicate that the patient uses insulin, code E11, Type 2 diabetes mellitus, should be assigned for type 2 patients who routinely use insulin.
  – code Z79.4, Long-term (current) use of insulin, should also be assigned to indicate that the patient uses insulin.

Example

• A 45-year-old type II patient returns to his physician’s office for a 3-month follow-up visit. The patient has been on insulin for the past eight months because the diabetes was not well controlled. After an expanded problem-focused history and physical examination, the physician documents in the medical record, “Type II diabetes mellitus currently maintaining good control with insulin, diet, and exercise. Patient will continue with same medication dosage, monitor glucose levels with home monitoring system, and return in 3 months for recheck. We may consider discontinuing insulin if patient remains in good control.
  – E11.9 Type 2 diabetes mellitus without complication
  – Z79.4 Long-term (current) use of insulin
Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)

• Site and laterality
  – Most of the codes within Chapter 13 have site and laterality designations
    • Site represents either the bone, joint or the muscle involved
  – For some conditions where more than one bone, joint or muscle is usually involved, such as osteoarthritis
    • There is a “multiple sites” code available
  – For categories where no multiple site code is provided and more than one bone, joint or muscle is involved
    • Multiple codes should be used to indicate the different sites involved

Example

• A patient is treated by an Orthopedic surgeon for osteoarthritis of the right knee. The patient complains of chronic knee pain that worsens at night. The physician prescribed an anti-inflammatory drug to relieve the pain.
  – First listed diagnosis: M17.11 Unilateral primary osteoarthritis, right knee
Bone versus Joint

- For certain conditions, the bone may be affected at the upper or lower end, (e.g., avascular necrosis of bone, M87, Osteoporosis, M80, M81)
- Portion of bone affected may be at the joint: the site designation will be the bone, not the joint

Coding of Pathologic Fractures

- 7th character “A” is for use as long as the patient is receiving active treatment for the fracture
- 7th character, “D” is to be used for encounters after the patient has completed active treatment
  - The other 7th characters, listed under each subcategory in the Tabular List, are to be used for subsequent encounters for treatment of problems associated with the healing, such as malunions and nonunions, and sequelae
  - Care for complications of surgical treatment for fracture repairs during the healing or recovery phase should be coded with the appropriate complication codes.
Coding of Traumatic Fractures

• Fractures of specified sites are coded individually by site in accordance with both the provisions within categories S02, S12, S22, S32, S42, S52, S62, S72, S82, S92 and the level of detail furnished by medical record content.
  – A fracture not indicated as open or closed should be coded to closed
  – A fracture not indicated whether displaced or not displaced should be coded to displaced

Initial vs. Subsequent Encounter for Fractures

• Traumatic fractures are coded using the appropriate 7th character extension for initial encounter (A, B, C) while the patient is receiving active fracture treatment.
  – Fractures are coded using the appropriate 7th character extension
    • for subsequent care for encounters after the patient has completed active treatment of the fracture and is receiving routine care for the fracture during the healing or recovery phase
Example

• A patient underwent surgery for an open burst fracture of the lumbar vertebra that became unstable.
• First listed diagnosis: S32.012B
  – Seventh character “B” identifies the initial encounter for the open fracture.

Chapter 15: Pregnancy, Childbirth, and the Puerperium (O00-O99)

• General Rules for Obstetric Cases
• Trimesters are defined as follows:
  – 1st trimester - less than 14 weeks 0 days
  – 2nd trimester - 14 weeks 0 days to less than 28 weeks 0 days
  – 3rd trimester - 28 weeks 0 days until delivery
Final character for trimester

- The majority of codes in Chapter 15 have a final character indicating the trimester of pregnancy
  - The timeframes for the trimesters are indicated at the beginning of the chapter
- If trimester is not component of a code
  - It is because the condition always occurs in a specific trimester, or the concept of trimester of pregnancy is not applicable

Case Examples

The patient has been increasing her smoking use; she is up to 1/2 pack per day. She is waking up with chest discomfort, tightness, and shortness of breath. She recently found herself smoking in front of one of her children and she has decided that she needs to quit smoking.

Blood pressure is 140/70, weight is 101.56 kilograms. Heart rate regular rate and rhythm, no murmurs. Lungs are clear to auscultation bilaterally. Abdomen has positive bowel sounds times 4 quadrants. There is CVA tenderness and left lower quadrant pain on palpation. There is no guarding and no rebound tenderness. Skin is clear without rashes, erythema, or jaundice.

1. Left nephrolithiasis.
2. Urinary tract infection with beta hemolytic strep
3. Tobacco abuse, uncontrolled
4. Elevated blood pressure secondary to pain.

1. The patient will stop her Ciprofloxacin.
2. A prescription for amoxicillin 500 mg p.o. b.i.d. times 7 days.
3. Vicodin 5/500 1 to 2 p.o. every 4 hours p.r.n. pain. 40 were given with no refills.
4. Chatrin. The side effects were discussed with the patient, as well as instructions for taking this with food. The patient was also encouraged to take this medication after she passes her kidney stone.
Case Examples

IMPRESSION: Cellulitis and superficial abscess on index finger.
PLAN: I am recommending debridement and irrigation of the digit today. I think the skin is dead and that she will tolerate it without anesthesia. I would like her to stay on the clindamycin and I will check her back in 3 days to see how she is doing.

Case Examples

Enter Code: 681.00

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTOR</th>
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<tbody>
<tr>
<td>L02.511</td>
<td>Cutaneous abscess of right hand</td>
</tr>
<tr>
<td>L02.512</td>
<td>Cutaneous abscess of left hand</td>
</tr>
<tr>
<td>L02.510</td>
<td>Cutaneous abscess of unspecified hand</td>
</tr>
<tr>
<td>L03.011</td>
<td>Cellulitis of right finger</td>
</tr>
<tr>
<td>L03.012</td>
<td>Cellulitis of left finger</td>
</tr>
<tr>
<td>L03.019</td>
<td>Cellulitis of unspecified finger</td>
</tr>
<tr>
<td>L03.021</td>
<td>Acute lymphangitis of right finger</td>
</tr>
<tr>
<td>L03.022</td>
<td>Acute lymphangitis of left finger</td>
</tr>
<tr>
<td>L03.029</td>
<td>Acute lymphangitis of unspecified finger</td>
</tr>
</tbody>
</table>
Case Examples

PROBLEM: Foreign body in nose.

HISTORY OF PRESENT ILLNESS: The patient is a 2-year-4-month-old child who comes in today after having put a raisin in her left nostril. Grandmother was unable to remove this.

EMERGENCY DEPARTMENT COURSE: The raisin was grasped with bayonet forceps and removedatraumatically. Examination of the nostril fails to reveal any further foreign body or problems.

DIAGNOSIS: Foreign body removal, nostril.

Case Examples

Enter Code: 932

ICD-9 932 > ICD-10

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>T17.0XXA</td>
<td>Foreign body in nasal sinus, initial encounter</td>
</tr>
<tr>
<td>T17.1XXA</td>
<td>Foreign body in nostril, initial encounter</td>
</tr>
</tbody>
</table>
Case Examples

Placenta and AP: Placenta is posterior/anterior, grade 0. Amniotic fluid volume is WNL.
Maternal Adnexa: No abnormality seen.
Impression: EGA 24.6 wks by measurements, fetus 701 gms.
Case Examples

- ICD-9 to ICD-10
- ICD-10 to ICD-9

Enter Code: 715.36  Lookup

Code Not Found

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Case Examples

Assessment #1:
Plan:
Med Current
Lab:
250.00 Diabetes Mellitus W/ Comp! Type ii Or Unspec Controlled
- Metformin HCL 500 mg 1 qd bid
- Lipid Screen
Assessment #2:
Plan:
Comments
Med Current
357.2 Polyneuropathy In Diabetes
- MAY ALSO HELP WITH MOOD STABILITY
- Neurontin 100 mg
take 1 tablet in the morning, 1 tablet
at noon and 2 tablets at bedtime
Questions??