Setting the Facts Straight About ICD-10: What Physicians Need to Know About the Transition

Since the publication of the final rule for adoption of ICD-10-CM and ICD-10-PCS ("ICD-10") in 2009, much attention has been paid to the new coding system's implementation. While many organizations see the benefits of using ICD-10, including the ability to capture more detailed information, others have concerns, including the costs of implementation. Despite the significant amount of information that has been published about ICD-10 during the last 10 years, many misconceptions persist today. The information below covers basic facts about the ICD-10 transition that are of particular interest to the physician community.

ICD-10-CM and ICD-10-PCS: Background

ICD-10-CM (International Classification of Diseases -10th Revision-Clinical Modification) is designed for classifying and reporting diseases in all US healthcare settings. It is the US version of ICD-10 developed by the World Health Organization (WHO).

ICD-10-CM (Diagnosis Coding System) was developed and is maintained by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS). All modifications to ICD-10 must conform to WHO conventions.

ICD-10-PCS (Procedure Coding System) replaces the ICD-9-CM procedure coding system and will only be required for hospital reporting of inpatient services. ICD-10-PCS was developed and is maintained by the Centers for Medicare & Medicaid Services (CMS). Unlike ICD-10-CM, ICD-10-PCS does not have a WHO international equivalent coding system.

The development of ICD-10-CM and ICD-10-PCS involved extensive input from the healthcare industry, including the physician community. Much of the additional clinical detail, which contributed to additional codes, was recommended by physician groups.

ICD-10-CM and ICD-10-PCS are maintained by the ICD-10 Coordination and Maintenance (C&M) Committee, which is a federal interdepartmental committee comprised of representatives from CMS and NCHS. This committee provides an open public forum to suggest and discuss proposed changes to ICD-10-CM and ICD-10-PCS. Input is welcome from all stakeholders, including individual physicians, physician organizations, other stakeholders, and private citizens. Physician groups, including medical specialty societies, actively participate in the coding system modification process by proposing new codes as well as commenting on the merits of suggested modifications. More information on the ICD-10 C&M Committee is available at: www.cdc.gov/nchs/icd/icd9cm_maintenance.htm.

Who Is Affected

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines "covered entities" as health care providers, including physicians, health care clearinghouses, and payers. All HIPAA-covered entities must begin reporting ICD-10 codes following the compliance deadline.

Organizations that use ICD-9-CM codes, but are not covered by HIPAA, should be aware that payers may nonetheless require its use. Because ICD-9-CM will no longer be maintained after ICD-10 is implemented, those not covered by HIPAA may find they will need to make this change.

ICD-10 Compliance Date

Federal regulation requires ICD-10 codes be used instead of ICD-9-CM codes for services provided on or after October 1, 2015. This means that claims for ambulatory and physician services provided on or after this date must use ICD-10-CM diagnosis codes, and hospital inpatient claims for discharges occurring on or after this date will use ICD-10-CM and ICD-10-PCS codes. ICD-9-CM codes must continue to be used for all dates of service on or before September 30, 2015.

No Impact on CPT

ICD-10 procedure codes will only be used for facility reporting of hospital inpatient services. Current Procedural Terminology (CPT®) codes will continue to be used for physician and outpatient services, as well as for physician billing of inpatient services.

ICD-10 and ACA

The requirement to implement ICD-10 is not part of the Patient Protection and Affordable Care Act of 2009 (ACA), a common misperception. The federal government is authorized under HIPAA to require the use of updated code sets. The final rule to implement ICD-10 was published on January 16, 2009, and is under the regulatory purview of HIPAA. ACA was not signed into law until April 2010.

Why the Change to ICD-10

Developed in the 1970s, the ICD-9-CM codes do not reflect all of the changes that have taken place in healthcare over the last more than 40 years. ICD-9-CM codes are missing new clinical knowledge and contemporary medical terminology. In addition, its limited structural design

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lacks the flexibility to keep pace with changes in medical practice and technology. The structure of ICD-9-CM limits the number of new codes that can be created, and many ICD-9-CM categories are full. Without significant changes, data on new diseases and technology, or important distinctions in diagnoses and procedures, may not be captured, limiting the potential to analyze healthcare costs or outcomes, exchange meaningful healthcare data for individual and population health improvement, and move to a payment system based on quality and outcomes.

ICD-9-CM is also being used for many more purposes than what it was originally intended for, including for reimbursement purposes. Greater specificity of clinical conditions and services delivered may provide payers, policy makers, and providers with better information to improve reimbursement systems.

Alternatives to ICD-10

While stakeholders have suggested implementing SNOMED-CT or ICD-11 instead of ICD-10, there are several reasons why these code sets are not viable alternatives. SNOMED-CT is a clinical terminology and ICD is a classification system. Terminologies and classifications are designed for distinctly different purposes and satisfy diverse user requirements. SNOMED-CT and ICD-10 are complementary, not interchangeable, systems. SNOMED-CT complements ICD-10 by serving as the foundation of clinical information in an electronic health record (EHR) from which ICD-10 data are derived. Together, terminologies and classifications provide the common medical language necessary for the effective sharing of clinical data.

As for ICD-11, the earliest it is projected to be released by the WHO is 2017. It would be at least several years after that date before ICD-11 is ready for implementation in the US. Rulemaking to adopt ICD-11 as a HIPAA code set would also be required.

Value of Adoption of ICD-10-CM

Although some healthcare providers view the ICD-10 transition as costly and burdensome, particularly during a time of other regulatory mandates, there are many benefits to moving to ICD-10-CM. ICD-10-CM medical terminology and classification of diseases are more consistent with current clinical practice than ICD-9-CM. It is expected that ICD-10-CM will support:

- Improvements in patient outcomes and patient safety through better data for analysis and research
- Improved ability to manage chronic diseases by better capturing patient populations
- More accurate reflection of clinical complexity and severity illness in patients
- Improved ability to identify high-risk patients who require more intensive resources
- Improved ability to manage population health

- Improved information sharing, which can enhance treatment accuracy and improve care coordination
- Enhanced public health surveillance and improvement strategies
- Improved ability to assess effectiveness and safety of new medical technology
- Improved administrative efficiencies and lowered costs (e.g., fewer rejected and improper reimbursement claims, decreased demand for submission of medical record documentation)
- Justification of medical necessity
- More accurate and fair reimbursement
- More accurate representation of provider performance
- Increased patient engagement (as a result of access to better data)
- Validation for reported evaluation and management codes
- Less misinterpretation by auditors, attorneys, other third parties

Number of ICD-10-CM Codes

There is a sizeable increase in the number of diagnosis codes in ICD-10-CM, though laterality (right vs. left) accounts for nearly half of the increase in the number of codes.

An increase in number of codes does not make it harder to locate the right code, any more than the size of a dictionary or phone book affects the ease with which a word or phone number is looked up. The Alphabetic Index and automated coding tools will still be available to facilitate proper code selection. While there will be a learning curve to become familiar with ICD-10-CM, ultimately it is anticipated that it will be easier to use than ICD-9-CM because of the increased specificity, greater clinical relevancy, and improved logical structure. The ambiguity and use of obsolete terminology in many ICD-9-CM codes contribute to difficulty in determining the correct code as well as differing interpretations among coders, payers, and auditors. The availability of increasingly sophisticated automated coding tools will also facilitate proper code selection and help to increase coding accuracy and productivity and compliance with payer policies. Just as no healthcare provider uses every code in ICD-9-CM today, physicians and other providers will not use all the codes in ICD-10-CM. Education can be tailored to the subset of codes relevant to the provider's patient population. In addition, the Alphabetic Index and automated coding tools will still be available to facilitate proper code selection.

External Cause Codes

Population-based injury data assist public health authorities in identifying and tracking patterns and trends in the external causes of fatal and nonfatal injuries and in designing and implementing effective injury prevention strategies.

Just as with ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required.

Reporting of these codes usually apply to limited circumstances and will not likely be a day-to-day requirement. Many of the external cause codes that have garnered attention were present in ICD-9-CM.

Information on the specific mechanism of injury is used for informing prevention programs. For example, injury prevention programs rely on external cause data to understand and effectively respond to leading types of injuries and high-risk populations (e.g., all terrain vehicle-related and farming-related injuries in rural areas, falls among older adults). States participating in the National Highway Traffic Safety Administration's Crash Outcome Data Evaluation System, which links data on the characteristics of the crash incident, the vehicles involved, and the people injured to specific medical and financial outcomes, also rely on high quality external cause coded data to identify motor vehicle injury prevention factors.

External cause codes can also explain whether an injury is work-related.

Using Sign/Symptom and Unspecified Codes

Sign/symptom and "unspecified" codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflects what is known about the patient's condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation.

Use of General Equivalence Maps (GEMs)

The GEMs are a tool for converting data (such as large databases) from ICD-9-CM to ICD-10-CM and ICD-10-PCS and vice versa.

The GEMs should not be used for claim submission. In order to accurately reflect a patient encounter and represent compliant coding, codes reported on claims should be assigned by using the coding system and should be based on medical record documentation.

ICD-10 and Paper Claim Forms

From a regulatory standpoint, ICD-10 adoption is a HIPAA requirement, and HIPAA only applies to the electronic standard transactions that have been adopted under this regulation. Since the use of paper and other manual processes to complete administrative transactions fall outside the scope of HIPAA, the requirement for ICD-10 adoption does not technically apply to non-electronic transactions.

It would, however, be too much of a burden on the healthcare industry to use ICD-10 in electronic transactions and ICD-9-CM in manual transactions. Thus, payers are expected to align electronic and paper claim submission requirements so that the use of ICD-10 codes will be required for both HIPAA and non-HIPAA transactions.

Matches of ICD-9-CM to ICD-10-CM Codes

Many have expressed concern about the expanded number of ICD-10-CM codes; however, analysis has shown that when mapping ICD-9-CM to ICD-10-CM codes, approximately 78 percent of the ICD-9 codes map "one-to-one" with an ICD-10-CM code. These one-to-one matches may be exact or approximate, with "approximate" meaning that it is the best match and carries the same intent. The remaining 22 percent of ICD-9-CM codes have a "one-to-many" match and will be more complicated for identifying an appropriate ICD-10-CM code.

Code selection software is available to help physicians select the appropriate ICD-10-CM code. There will be a learning curve and productivity issues with ICD-10-CM, but physicians may find the increased specificity, greater clinical relevancy, and improved logical structure may be more logical than ICD-9-CM.

Physicians will recognize the wording of many of the diagnoses they use today in ICD-9-CM when they begin to look at the ICD-10-CM codes.

Spanning the Compliance Date

The ICD-10 compliance date is based on the date of service, not the date on which the claim or other transaction is submitted. Therefore, it is possible to have a claim for a service that spans the compliance date.

Institutional claims (e.g., hospital inpatient, nursing home, inpatient rehabilitation) have a greater likelihood of spanning the compliance date. CMS has issued guidance to the Medicare Administrative Contractors (MACs) on how to report institutional services that span the compliance date, which is located at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf. Providers will need to check with their other payers for instructions on how to report services that span the compliance date.

With professional claims, the services are more likely to be specific to one date and not a range of dates. Reporting the claim will follow the requirements of the ICD-10 regulation, which states that services provided before and on September 30, 2015, will use ICD-9-CM and services performed on and after October 1, 2015, will use ICD-10.

There may be a small number of claims that are reported using the professional claim format that do include a range of dates, such as home health or supplies. Physicians and other healthcare providers will need to check with the payers to which they are submitting the claim to determine the specific instructions to do this.

ICD-10-CM Training for Physicians

The amount of training a physician will need for ICD-10-CM will vary based on the role they play within their organization and in coding claims. As a starting point for training, physicians should focus on their specialty.

For physicians employed in hospitals and health systems, ICD-10-CM coding will be done almost exclusively by coders. Physicians will focus on learning overall concepts that impact their specialty and any changes that may be needed for their documentation. Hospitals or health systems may provide training for the physicians on these changes.

For physician practices, the amount of training will depend on the role the physician has in coding. If the physician does no coding, then training will be limited to the overall concepts of the specialty and any documentation changes. The physician may want to learn more about coding, if they wish. If the physician does any amount of coding, then they will need to have full training on the code set and coding guidelines.

All physicians should check with their specialty or medical society for training recommendations and resources.

Documentation for ICD-10-CM

Concerns have been raised about potential changes that clinicians will need to make to their documentation to support ICD-10-CM coding. While some improvements in documentation may be beneficial for ICD-10-CM coding, many concepts in ICD-9-CM have not changed in ICD-10-CM.

Practices should complete a documentation assessment to determine how their current documentation will support coding in ICD-10-CM. This activity can be completed now using existing patient records by taking a current chart, coding it in ICD-10-CM, and determining if there is enough information in the record to capture the necessary concepts for ICD-10-CM.

Conducting a clinical documentation assessment is an important step toward preparing for the transition to the ICD-10-CM. Knowing the clinical documentation requirements of ICD-10-CM and understanding the similarities and differences between the clinical concepts of ICD-9-CM and ICD-10-CM may help to alleviate concerns about the complexity of ICD-10-CM.

Resources to Assist Physicians Transition to ICD-10-CM

There are many free and low-cost educational and implementation resources available to help physicians transition to ICD-10-CM, from CMS as well as professional associations and commercial entities.

CMS has many free resources to assist physician practices and other providers with the ICD-10-CM transition, including fact sheets, implementation guides, checklists, timelines, webinars, and provider teleconferences.

CMS's "Road to 10" offers training, tools, and resources to help small physician practices make the transition.

The ICD-10-CM coding system is available free of charge from CMS and NCHS.

The *ICD-10-CM Official Guidelines for Coding and Reporting* are available free of charge from NCHS.

The American Health Information Management Association and American Medical Association also offer ICD-10 education, tools, and resources, many of which are free.

"Rural ICD-10" offers information and free resources to assist rural health providers in transitioning to ICD-10.

A number of professional associations, including medical specialty societies, offer free or low-cost ICD-10 education and resources for both members and non-members.