Preparing for ICD-10: Is It Happening Or Not?

Written by Jonathan L. Elion MD, FACC | Monday, 02 March 2015 00:00

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The initial confusion caused by last year's congressional action to delay adaption of ICD-10 has died down, but once again the topic is sneaking back into the headlines. Last year many were asking, "what if they gave a party and nobody came?" This year many find themselves channeling Pete Townshend of The Who in declaring "we won't get fooled again!" In the midst of all this confusion and the myriad of predictions, what should providers be doing now to prepare for ICD-10?

Outsourced Coding

Many doctors are rightfully concerned about running a business (namely, their office-based practices) in this day and age, and they are wondering how all of this will impact their bottom lines. Predictions on how ICD-10 will affect coder productivity vary widely, but most agree that coders will see somewhere between a 25 to 50 percent reduction in productivity. So, the first thing to look at is how this might impact your office workflow. Do you have a full-time coder or coders? Will you need more, or do they have the ability to devote the increased time required to code each chart in ICD-10? Has your staff been trained yet in ICD-10, and if not, how much will it cost for training and for staff to be away from the job for that training?

One common solution that helps ease this pain is to outsource part or all of the coding (this applies to both hospital-based and office-based coding). This shifts the financial risk to the coding service, as the office practice (or hospital) can negotiate fees that help them accurately predict their coding costs. This approach is certainly worth careful consideration (and is still applicable if there is another delay).

Documentation Training

Physicians absolutely must be educated about the principles of proper and complete clinical documentation. There is a gap between the notes we write to communicate, clinician-to-clinician, and those needed by the hospital to properly code and bill each encounter. Proper training on how to write notes that close that gap will go a long way towards ensuring ICD-10 compliance.

But do we need note-writing training specifically geared toward ICD-10? I recently had to complete ICD-10 training for cardiology in order to maintain admitting privileges at my hospital. While the color slides were pleasant enough, there was little in the training that could not have been covered by two simple phrases: "due to" and "manifested by" (which, if you think about, is really the inverse of "due to").

This is an approach that can be implemented immediately – every time you write an assessment in a note, look for opportunities to use "due to" or "manifested by" for each problem that is described. For example, rather than indicating that the patient has a gastric ulcer, a GI bleed, and anemia, it would be far better to say that the patient has a GI bleed due to a bleeding gastric ulcer, and anemia due to the GI bleed. Simple!

While we are at it, there is one new acronym to learn: M.E.A.T. For every condition you mention in a clinical note, you should indicate whether that condition was **M**-monitored, **E**-evaluated, **A**-assessed, and/or **T**-treated. This will help in getting providers full and proper credit for treating conditions that go into risk-adjusted reimbursement models, such as Medicare Advantage. While this currently only accounts for about 25 percent of Medicare patients, the risk-adjusted model is gaining traction, and there is no reason to wait to improve your notes to be ready.

Specificity for Procedure Codes and Documentation

One final area that deserves special attention relates to procedures. ICD-10 demands a new level of documentation specificity. There are few procedure codes in ICD-10 that will allow “not otherwise specified” (NOS) codes, as are allowed in ICD-9. In the ICD-9 coding environment, it is still possible to generate a code and get reimbursement even with minimal specificity. But under ICD-10, if specificity is lacking, there may not be a procedure code that can be used, and the reimbursement will suffer.

Let’s look at “lysis of adhesions” to see how this works (or doesn’t work). If a surgeon performs a laparoscopic procedure to free up something in the abdomen that’s trapped in scar tissue and the operative note reads “laparoscopic lysis of peritoneal adhesions,” that would be enough information to use ICD-9 code 54.51. But there is no direct equivalent in ICD-10, as you need to describe exactly what was released during the procedure. So, it if was a loop of small bowel caught up in adhesions, this would be ICD-10 code 0DN84ZZ (release small intestine, percutaneous endoscopic approach) – and it would still require specific mention of the small bowel in order to be coded. Physicians who perform a lot of office-based procedures may experience a dramatic drop in reimbursement if this is not anticipated and handled correctly. This is a good time to get in the habit of looking up ICD-9 codes that are being billed and making sure that there is a specific equivalent ICD-10 code. If there is not, you need to learn what additional information is needed to be able to code for the procedure under ICD-10. Start now!

Like it or not, we are being watched. Hospitals, HMOs, insurance companies, and other payers are profiling our clinical practices, our resource utilizations, and our outcomes. They are creating and using scorecards on individual physicians, not just hospitals and healthcare systems. And they're doing all this while using a coding system that was put into place in 1979. It's antiquated, out-of-date, and inadequate to codify modern medical procedures.

I like to think of it as trying to writing to write a Ph.D. dissertation using third-grade grammar. In order to fully code what we do, along with all the conditions and co-morbidities of our patients, we *must* update our methodologies – and that means using ICD-10.

Get used it to. And get prepared!

About the Author

Jon Elion, MD, is the president and CEO of ChartWise Medical Systems. Dr. Elion is a practicing board-certified cardiologist in Providence, R.I. and an associate professor of medicine at Brown University. He has served on the finance committee and board of trustees of one of the Brown-affiliated hospitals, and is well-versed in hospital finances. His experience provides him with the unique combination of in-depth medical and technology knowledge with a proven track record of entrepreneurship and business development.

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