Preparing for ICD-10-CM—Possibly the Biggest Challenge Facing Ophthalmology to Date

E. Ann Rose

On October 1, 2013, diagnosis coding as you currently know it will change dramatically. Just when you think you have it down pat, this change will have you starting all over again. It will almost have to be tackled with a “do or die” attitude, the changes are that huge. Fortunately, ophthalmology has great physicians and allied staff who have good drive and attitudes and will be able to weather the storm. Ophthalmology practices also have access to some of the best administrative tools in the industry thanks to the American Society of Ophthalmic Administrators.

Why tell you about the changes now when the actual ICD-10 diagnosis code set will not be effective until October 1, 2013? It’s because the mere magnitude of the conversion from ICD-9 to ICD-10 will require significant changes in your practice, including hours of training for physicians and staff. Budgeting for the new diagnosis code changes will also be a big challenge, particularly in smaller practices.

Background
The current diagnosis coding system in the United States is the International Classification of Diseases, Ninth Revision, Clinical Modification, which is the U.S. version of ICD-9 developed by the World Health Organization (WHO). ICD-9 was originally developed to classify mortality statistics (causes of death) and was later expanded to classify morbidity (presence of illness or disease). ICD-9-CM has become obsolete, and many of the clinical and procedural concepts are no longer able to meet today’s demanding healthcare data needs. In addition, outdated software and equipment are no longer supported by the WHO and cannot be modified to meet current and future needs.

ICD-9 vs. ICD-10
ICD-9 has outgrown the level of specificity for diagnosis coding. It no longer reflects advances in medical treatment. There are only five levels of specificity in ICD-9; ICD-10 has seven levels of specificity. There are very few unassigned codes remaining in ICD-9 for adding new diagnoses, and many of the current codes do not accurately describe the diagnoses they are assigned to represent. Also, many countries around the world are already using ICD-10, so it is difficult to compare U.S. data to the rest of the global community. The WHO only supports ICD-10 now because ICD-10 codes are more precise and will give healthcare providers the ability to code more accurately.

ICD-10 will require improved chart documentation from physicians and other healthcare providers. It will provide greater coding to support more accurate payments for hospitals, physicians, and health plans.

There are currently about 14,000 ICD-9 diagnosis codes. ICD-10 will contain more than 68,000 diagnosis codes. The good thing is that the majority of ophthalmology codes are now in one chapter. The new ICD-10 codes have greater specificity and expanded detail for identifying
injuries, diabetes, post-op complications, and alcohol/substance abuse. An expanded use of combination codes will need to be learned, and injuries are grouped by anatomical site rather than type of injury. ICD-10 contains additional characters to allow for identifying body system, root operation, body part, approach, and devices involved in a procedure. The differences are show in Table 1.

The Centers for Medicare and Medicaid Services (CMS) has posted 2011 diagnosis code crosswalks called GEMs (General Equivalence Mappings) on their website at www.com.gov/ICD10/. Both ICD-9 to ICD-10 and ICD-10 to ICD-9 crosswalks are listed on the website. Practices are encouraged to review these comparisons to become familiar with the coding differences. Just be aware that these GEMs will be updated annually to cover new diagnosis codes.

Feeling the Impact
ICD-10 will impact all healthcare providers, payers, software vendors, clearinghouses, and third-party billers. Key areas to consider initially include
• Staffing
• Vendor software
• Computer technology issues
• Clinical systems and forms
• Information management
• Impact on cash flow

In addition, electronic claims are currently submitted using the Version 4010 transaction code set. This version must now be converted to the new Version 5010 and Version D.0. computer systems that submit claims, receive remittances, and exchange claim status or eligibility inquiry, and responses must be updated to the new Version 5010 effective January 1, 2012. CMS does not expect a delay in this implementation date, so it is important for practices to confirm with their computer vendor that they have met the Version 5010 requirements.

Compliance timelines for the Version 5010 conversion were published by CMS (see Table 2).

Table 1. Differences in ICD-9 vs. ICD-10 Codes

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>3–5 Digits</td>
<td>3–7 Digits</td>
</tr>
<tr>
<td>All characters are numeric</td>
<td>Digit 1 is alpha (A–Z, not case sensitive) Digit 2 is numeric Digit 3 is alpha or numeric Digits 4–7 are alpha or numeric Not case sensitive</td>
</tr>
<tr>
<td>Supplemental chapters: First digit is alpha (E or V), remainder are numeric</td>
<td>————</td>
</tr>
</tbody>
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Table 2. Compliance Timeline

<table>
<thead>
<tr>
<th>Date</th>
<th>Compliance Step</th>
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<tbody>
<tr>
<td>December 31, 2010</td>
<td>Internal testing of Version 5010 completed by payers and providers</td>
</tr>
<tr>
<td>January 1, 2011</td>
<td>• Payers and providers should begin external testing of Version 5010 electronic claims • CMS begins accepting Version 5010 claims • Version 4010 claims continue to be accepted</td>
</tr>
<tr>
<td>December 31, 2011</td>
<td>External testing of Version 5010 for electronic claims must be completed to achieve level II Version 5010 compliance</td>
</tr>
<tr>
<td>January 1, 2012</td>
<td>• All electronic claims must begin using Version 5010 • Version 4010 claims will no longer be accepted</td>
</tr>
<tr>
<td>October 1, 2013</td>
<td>Claims for services provided on or after this date must use ICD-10 diagnosis codes when submitting claims for payment</td>
</tr>
</tbody>
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continued on page 62
Physicians and staff must understand how to rewrite clinic notes, and coders will need specificity from clinic staff in order to code properly. Improperly coded claims could result in claim denials or payment reversals. Documentation will be required to support the diagnosis or procedure and ensure the service is consistent with patient symptoms.

Extensive training will be required for physicians, clinical staff, coders, billers, front office staff, managers, administrators, and auditors/reviewers. The learning curve might be quite steep, especially in small- to medium-sized practices that do not employ certified professional coders. CMS initially thought 4 to 10 hours of training would be adequate, but now believes one day might not be enough. Other studies suggest 24 to 80 hours for coders and 10 to 12 hours for physicians and nurses. Coders will now need to understand anatomy and physiology more extensively; this understanding is not required in ICD-9.

There are currently many types of training tools available such as courses, workshops, seminars, web-based training, printed materials, and audio conferences. It is imperative that practices take advantage of these training tools in order to be prepared for the transition, and that means physicians, too. CMS suggests that staff trained too early will forget much of the information by October 1, 2013. If trained too late, staff will be overwhelmed with training and the final steps implemented all at once. Approximately 1 year prior to the “go-live” date of October 1, 2013 is considered an appropriate window for optimal training. While that date may seem far away, providers should now begin working toward implementation of the new ICD-10 codes.

Preparing for ICD-10
Potential impact on reimbursement is suggested to be about 10–25% of a practice’s productivity, due to slower payments for 3 to 6 months. This could be caused by queries from coders to clarify documentation in the medical record, increased billing inquiries by payers, and an increased number of adjustments and pending or suspended claims. Hiring additional trained staff might be required because of an increased need to review charts and encounter forms or superbills for compliance.

The Medical Group Management Association (MGMA) has projected the potential costs, in dollars, of implementing ICD-10: about $27,000 for a solo practice; $83,000 for a small practice (three to five physicians); and $285,000 for a medium-sized practice (10 physicians).

Take these steps into consideration when preparing for ICD-10:
- Work with your computer vendor and billing clearinghouses to make sure they are 5010 compliant and tested as such.
- Be prepared to change encounter forms and superbills.
- Modify pre-printed chart sheets.
- Upgrade EMR/EHR charting requirements.
- Identify staff to be trained.
- Test claims submission with trading partners, payers, and clearinghouses.
- Budget for implementation costs, expenses for system changes, resource materials, and training.

The biggest obstacle a practice will have to overcome could be resistance to change, resulting in staff turnover.

Start Now
The change to ICD-10 will affect every aspect of healthcare for providers and practices, including quality measures, documentation, medical coverage, payment policies, productivity, and more. Because Medicare payment to physicians is driven by coverage and reimbursement policies, coverage decisions will be based not only on procedures, but also on medical necessity, interpreted from the new diagnosis codes. There could be payment delays, either due to CMS processing or to having submitted incorrect or old codes, resulting in a rejection of your claims and other transactions—so providers are encouraged to stay updated on new medical policy changes to ensure reporting correct ICD-10-CM diagnosis codes.

The bottom line is that providers cannot afford to take this change lightly. Practices should begin now to formulate a needs analysis to prepare for ICD-10 implementation, effective October 1, 2013. Taking the high road now and (to borrow a phrase from the Boy Scouts) “being prepared” for this astronomical conversion will be your best defense to avoid claim denials and slower reimbursements.

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