ICD-10 Transition: Your Biggest Questions Answered

Presented to you by
The Cooperative of American Physicians, Inc.
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Introduction

On October 1, 2015, all medical practices will be required to adopt new ICD-10 coding.

A widespread, comprehensive implementation of a new diagnosis code hasn’t been done in more than a generation of physicians. While it’s key to modernizing the way physicians practice medicine, the process can place a great deal of stress on you and your practice if you’re not properly prepared.

We’ve heard many questions from physicians and practice managers regarding the transition. Here, nationally recognized health care educator, founding principal of The Sage Associates, and ICD-10 expert Mary Jean Sage answers your biggest questions about ICD-10.

These frequently asked questions and their answers will assist you and your practice in adopting the new code set. We hope you find this information valuable as you transition to ICD-10.
The Basics

When will ICD-10 be implemented?

The U.S. Department of Health and Human Services (HHS) issued a rule on July 31, 2014 that ICD-10, both CM (Clinical Modifications) and PCS (Procedural Coding System) will be implemented into the HIPAA mandated code set on October 1, 2015.

What does the grace period announced on July 6, 2015 mean?

The guidance issued by the Centers for Medicare & Medicaid Services (CMS) is intended to provide flexibility in the claims auditing and quality reporting process as physicians and other members of the medical community gain experience using the new code set. The guidance provides:

- Medicare contractors will not deny claims based solely on the specificity of the ICD-10-CM code as long as a valid ICD-10 code from the right family of codes is used. Moreover, physicians will not be subject to audits as a result of ICD-10 coding mistakes during the first 12 months following ICD-10 implementation.

- Physicians will not be penalized under the various CMS quality reporting programs (PQRS, MU) for errors related to the additional specificity of the ICD-10-CM code, as long as a valid code from the right family of codes is used.

- If Medicare contractors are unable to process claims within established time limits because of ICD-10 administrative problems, such as contractor system malfunction or implementation problems, CMS may in some cases authorize advance payments to physicians.

CMS also announced the establishment of a communication center and an ICD-10 ombudsman to help receive and triage physician and provider issues.

While the grace period does allow for some flexibility, we strongly advise physicians to still be fully prepared for the October 1 implementation.
How do I know which system to bill under – ICD-9 or ICD-10?

It is important to remember that ICD-10 coding is based on **date of service**, **not date of billing**. For example, if a patient was admitted to the hospital on September 27, 2015 and was discharged on September 30, 2015 and you bill the service on October 3, 2015, you will still bill those services with ICD-9 because the **date of service** was prior to October 1, 2015. However, if a patient presents to your office on or after October 1, 2015, you must bill that out with ICD-10.

You will be required to run a billing system that can handle both ICD-9 and ICD-10 for a time after the implementation of ICD-10. The ICD-9 system will need to be maintained until all claims prior to October 2015 have been submitted and resolved. This could take time, considering you may need time to resubmit claims electronically.

What is the difference between ICD-10-CM and ICD-10-PCS, and will I continue to use Current Procedural Terminology (CPT®) Codes?

ICD-10-CM is designed for classifying and reporting diseases (diagnosis) in all health care settings. ICD-10-PCS (Procedural Coding System) replaces the ICD-9-CM procedure coding system and will only be required for hospital reporting of inpatient procedure services. Physicians will continue to use CPT for reporting their professional services.
**Who has to comply with ICD-10?**

All HIPAA-covered entities must convert to ICD-10-CM for reporting diagnoses and ICD-10-PCS for facility reporting of inpatient services. Workers’ compensation is excluded from this, but many payers have indicated they will be converting to ICD-10 as well.

**How does this affect a specialty such as anesthesia for ICD-9/ICD-10 coding and billing on a HCFA 1500?**

No specialty is exempt from using ICD-10-CM coding beginning October 1, 2015. You will need to use ICD-10-CM codes on your insurance claims, just as all other HIPAA-covered entities must. Remember, physicians will continue to use CPT to report their professional services and ICD-10-CM only to report diagnoses.

No specialty is exempt from using ICD-10-CM coding.
Transition

**How is ICD-10 different from our current system?**

In many ways, ICD-10 is quite similar to ICD-9. The guidelines, conventions, and rules are very similar. The organization of the codes is very similar as well. Anyone who is qualified to code ICD-9 should be able to make the transition to coding ICD-10.

Many improvements have been made to coding in ICD-10.

For example, a single code can report a disease and its current manifestation (e.g., type 2 diabetes with diabetic retinopathy). In fracture care, the code differentiates an encounter for an initial fracture; follow-up of fracture healing normally; follow-up with fracture in malunion or nonunion; or follow-up for late effects of a fracture. Likewise, the trimester is designated in obstetrical codes.

ICD-10 comprises roughly 68,000 diagnosis codes, versus about 14,000 for ICD-9. No physician will ever use all 68,000 diagnosis codes or anything close to that number. Just like today, physicians will use a limited number of codes within their specialty.

While much has been said about the huge increase in the number of codes under ICD-10, some of this growth is due to laterality. While an ICD-9 code may identify a condition of the ovary, for example, the parallel ICD-10 code identifies four codes: unspecified ovary, right ovary, left ovary, or bilateral condition of the ovaries.

The differences between the two systems are those that will significantly affect information technology and software at your practice.

*In the past, we have been limited to how many diagnoses we can put on a claim. With ICD-10, will we still be limited to the amount of diagnoses codes?*

The code set (ICD-10-CM) does not determine how many diagnoses can be reported on a claim. The claim format makes that determination. Currently, the CMS 1500 claim form allows 12 diagnosis codes to be reported on a claim; the 5010 electronic claim form allows an unlimited number of diagnoses.
A patient is placed in observation after surgery on September 30, 2015 and discharged October 1, 2015. Do I use ICD-9 or ICD-10 coding?

If observation is considered outpatient, then use ICD-9 for September 30 and ICD-10 for October 1. If observation is considered inpatient, then use ICD-10-CM for both days.

If I submit an ICD-9-coded claim prior to the compliance date and it is denied or rejected, when I resubmit the corrected claim after the compliance date should it be in ICD-10 codes?

It is not the date of claims submission that matters. Instead, it is the date of service (for professional services claims) or the date of discharge (for inpatient claims) that determines whether you will use ICD-9 or ICD-10 codes. You must use ICD-9 codes on claims for dates of service prior to the compliance date – even if you resubmit the claim after the ICD-10 deadline.

It is the date of service or the date of discharge that determines when you will use ICD-9 or ICD-10 codes.

Are insurers like Blue Cross, Blue Shield, and Aetna definitely ICD-10 ready?

Check with each of those companies for their readiness. Most have posted their ICD-10 plans/status information on their websites. You should sign up to test with each of them to confirm. Do contact all of your payers to check on their status/readiness for ICD-10 submission.
Can an insurance company choose to require ICD-9 after October 1, 2015 if it is not ready?

Not if it is a HIPAA-covered entity. Workers’ compensation and auto insurance carriers are not HIPAA-covered entities, so they may. But most workers’ compensation carriers have indicated their intent to move to ICD-10.

We are a small private practice that uses an outside billing vendor. We send them paper superbills. Do we get the new codes from them?

Every physician is responsible for selecting an accurate and correct diagnosis code for services he or she provides. Do not depend upon a billing service to provide the codes. You must learn ICD-10 and how to correctly code using the new code set. Your billing service may offer some education in ICD-10 and assist you in understanding what code to select, but do not depend upon them to crosswalk any codes or do code translation for you without your full understanding of ICD-10-CM.

Are there any companies we may hire to help come up with a new paper superbill for a physician practice that will not convert to EHR?

Check with the organization that produces your current superbill. There are companies that will assist in updating and converting your superbill. However, most practices that continue to utilize a paper superbill actually produce their own. It is the physician’s responsibility to ensure that the correct codes are submitted to the payer.
Training

*How do I determine what training is needed?*

While there will need to be significant education and training for coders, billers, practice managers, physicians, and other health care personnel to fully implement this major code change, not everyone needs the same type of training. We strongly recommend that you create an ICD-10 training plan that prepares all staff members — not just the medical coders. This training plan should include:

1. A thorough assessment of what there is to learn
2. The exact type of training each staff member will need, including training format (e.g., formal classroom sessions, in-house sessions, or remote, online sessions)
3. A training schedule
4. A realistic budget

Once your staff has completed ICD-10 training, consider what resources are available (manuals, online help or prompts, personal consultation, etc.) for resolving problems and questions as they arise in the course of the transition.

The transition to ICD-10 is a planning and learning process. Take steps now to learn the system’s structure and code selection requirements, so your practice is ready for the transition. Be sure to focus on your specialty-specific codes and those you will encounter/use most frequently in your practice.

*Any recommendations for training courses for physicians, staff, and billers?*

Check with your professional academy or local and state medical societies, as many offer training classes. AHIMA and AAPC also offer classes. If your organization is large enough, you may want to consider engaging a coding consultant.
Implementation

What will the transitioning to ICD-10 cost me?

Estimates of costs for converting a physician practice to ICD-10 have varied widely, depending on the source. Consider these important factors:

- Physicians need only the ICD-10 diagnosis codes. They can purchase a code book or they can download the code book for free from the Centers for Disease Control and Prevention website.

- Training in ICD-10 diagnosis coding, estimated to take about three hours, is available for physicians and for practice staff both online and in person at reasonable cost from specialty societies, coding organizations, and vendors.

- EHRs, for which many practices have received conversion funding, are the ideal platform for documentation templates needed to assign ICD-10 codes. Many EHR providers incorporate ICD-10 software upgrades automatically.

- Physician offices that rely on vendors (e.g., billing services, clearinghouses) can often receive free or low-cost ICD-10 software upgrades as part of their packages.

- For offices that use superbills, conversion to ICD-10 codes is a one-time process that can use common codes supplied for free by the Centers for Medicare & Medicaid Services (CMS), professional societies, and payer policies.

- CMS and many payers are making end-to-end testing available for free. It is recommended that you test with all payers as soon as possible. Test early enough to make corrections prior to October 1, 2015 to pursue uninterrupted revenue and minimal claim denials.

A study released in February 2015 by the Professional Association of Health Care Office Management (PAHCOM) shows the financial barriers to ICD-10 implementation for the small physician practice are dramatically less than originally projected. The survey of 276 physician practices of fewer than six providers revealed that total ICD-10 related costs for an entire practice averaged $8,167. Per-provider expenditures averaged $3,430.
Will it be reasonably possible to implement ICD-10 without a full EHR system?

ICD-10 can be implemented without an EHR system. It might be easier to implement with an EHR, especially if the EHR supports Computer Assisted Coding (CAC) technology. However, a practice can implement ICD-10 with hard copy or paper documents.

What other major vendors besides EMR/PM are affected?

You need to consider any vendor used for quality reporting, public health reporting, disease registries, and patient portals, as well as any clearinghouse you may utilize.
Compliance

Is reporting of external cause codes required?

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 external cause codes in ICD-10-CM is not required.

Will the order of coding affect the payment received?

At this time, not in the outpatient physician professional service arena.

There is no national requirement for mandatory ICD-10-CM external cause code reporting.
Conclusion

The current ICD-9 code set is more than 30 years old, does not reflect recent advances in medical technology and knowledge, and has a limited ability to expand.

The transition to ICD-10 will require significant adjustments, but is conducive to the refinement of our health care system. With proper preparation, medical practices should be able to manage the new code set and its associated costs well.

This set of frequently asked questions is part of our effort to support physicians like you with resources that address your everyday needs. We hope you found it useful.

CMS also offers Road to 10: The Small Physician Practice’s Route to ICD-10. This guide features common codes for your specialty, primer for clinical documentation, clinical scenarios, and training and education resources. A section is also provided to build your action plan.

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About Mary Jean Sage

As founding principal and Senior Consultant of The Sage Associates, Mary Jean Sage is a nationally recognized speaker, consultant, and educator with more than 20 years’ experience in health care. Her unique blend of administrative and clinical skills has earned her an enviable reputation as an expert in managed care operations and reimbursement management. She is recognized nationally for her expertise in coding and billing and the practical seminars and workshops she presents to health care professionals. Ms. Sage was instrumental in developing the Certified Medical Billing Associate program, which credentials medical billers, and served as the initial Certification Director for the program. She currently serves as an advisor to a number of billing and coding publications.

Ms. Sage received her degree in Business Administration from the University of Redlands and her degree in Allied Health from Ferris State University. She is a credentialed Certified Medical Assistant (CMA-AC).

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About CAP

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