



ICD 10: Are You Ready?

Getting Your Practice Through the Transition

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Before you know it, ICD 10 will be here...

- All claims with dates of service and inpatient claims with dates of discharge on and after **October 1, 2013** must be reported with ICD10
- If you continue to submit new claims using ICD 9 after October 1, 2013, you will likely experience multiple claim rejections....and a huge waste of staff time and resources in clean-up efforts

But CMS always delays the
implementation date
- why the rush?

Despite CMS's history of moving implementation dates, everything indicates that ICD 10 will move forward as planned.



Get going!

5010 Comes First

- The standards for electronic transactions are moving to Version 5010 starting January 1, 2012
- Covered transactions include all claims related transactions and eligibility inquires
- Version 5010 comes with many improvements, but two key features to note:
 - Increased field space as ICD 10 codes can have up to 7 characters
 - Increases the amount of diagnosis codes allowed on a claim

5010 Compliance Dates

- Level I Compliance
- December 31, 2010

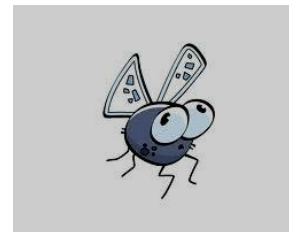
Level I compliance means "that a covered entity can demonstrably create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."*

- Level II Compliance
- December 31, 2011

Level II compliance means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."*

- By December 31, 2010 you should be able to demonstrate readiness to send and receive compliant transactions (you've tested your system internally and worked with your vendors to make sure the changes are in place)
- By December 31, 2010 you should have completed actual test transactions with any needed external parties to ensure that you are fully operational (you've sent and received dummy transactions to and from your insurance payers, claims clearinghouses, and all other vendors)

- For a while, your systems will need to be able to map ICD 9 to ICD 10 codes, and to accommodate both code sets, as claims from before October 1, 2013 will be run through the system, and some older claims may still need cleaning up
- The lag time between implementation of 5010 (January 1, 2012) and ICD 10 (October 1, 2013) will allow for time to clean up any problems practices may experience with their electronic transactions



... get the bugs out!

ICD 10

- ICD 10 diagnosis codes will be used for coding in all clinical areas- in-patient, out-patient, practices, and all facilities
- ICD 10-PCS codes will be used for reporting hospital in-patient procedures only
- CPT and HCPCS are not impacted and the use of these codes will not change

- ICD 10 codes are much more specific than their predecessors
- New format allows for the reporting of laterality and more detailed diagnoses
- The codes have been adjusted to include recent medical developments and new diagnoses that could not be specified in ICD 9, as well as leaving room to accommodate upcoming developments and diagnoses
- Better capturing of public health data through improved claims reporting

Comparing ICD 9 to ICD 10 Codes

ICD 9

- 3-5 characters in length
- Approximately 13,000 codes
- First digit may be alpha (E or V) or numeric; digits 2-5 are numeric
- Limited space for adding new codes
- Lacks detail
- Lacks laterality

ICD 10

- 3-7 characters in length
- Approximately 68,000 available codes
- Digit 1 is alpha; digits 2 and 3 are numeric; digits 4-7 are alpha or numeric
- Flexible for adding new codes
- Very specific
- Has laterality (i.e., codes identifying right vs. left)

Procedures

ICD 9

- 3-4 numbers in length
- Approximately 3,000 codes
- Based on outdated technology
- Limited space for adding new codes
- Lacks detail
- Lacks laterality
- Generic terms for body parts
- Lacks descriptions of methodology and approach for procedures
- Lacks precision to adequately define procedures

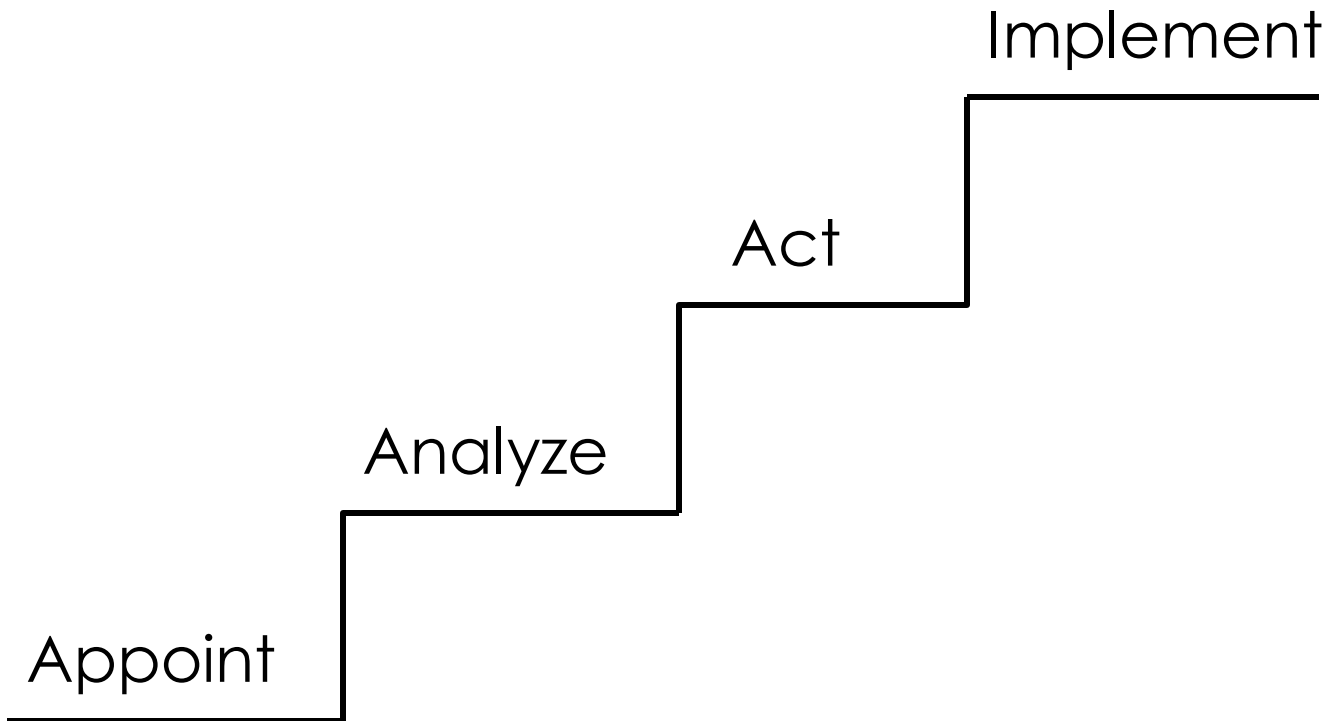
ICD 10

- 7 alpha-numeric characters in length
- Approximately 87,000 available code
- Reflects current usage of medical terminology and devices
- Flexible for adding new codes
- Very specific
- Has laterality
- Detailed descriptions for body parts
- Provides detailed descriptions of methodology and approach for procedures
- Precisely defines procedures with detail regarding body part, approach, any device used, and qualifying information

Getting from here to there . .



... In 4 Steps



Step 1: Appoint

- Getting from 9 to 10 will take organization and accountability
- Appoint a team to manage the transition and a team leader to manage the team
 - The team leader should be an administrator or manager
 - The team members should represent each of the different departments in your practice or facility
- The transition team should plan regularly scheduled meetings to discuss project needs, timelines, and accomplishments, with meeting one devoted to understanding 5010 and ICD 10 fundamentals and why the changes are needed

Step 2: Analyze

- Determine how every area in the practice or facility will be affected by the upcoming changes
 - This will require the transition team do a 'walk-through' of the practice- following both the patient flow through the office and the paper/electronic transaction trail to determine each and every step that requires coding or electronic operations
 - Take detailed notes on the following items in each department:
 - Any hardware, software or web-based applications that are being used and the vendors that manage your practice account
 - Any paperwork used that requires code listings, such as superbills, visit templates, test requisitions, and referral forms

- Two areas that can easily be overlooked during your team walk-through:
 - *Practice protocols and policies:* Many of these may have to be re-written to accommodate diagnosis based procedures and documentation. Carefully review your practice operations manual and any departmental manuals for items needing adjusting
 - *Practice interactions with insurance companies:* Not only will you need to ensure that you can electronically communicate with your payers for claims and other information and inquiry needs, but as codes change, so will payer coverage on certain diagnoses and procedures, requiring better monitoring of prior authorization and other notification or documentation requirements

- How will all of these changes impact your staff and patients?
 - Look for areas where delays are likely due to new forms, new processes and slowed operations. There will be a lag time as staff gets acclimated to the changes
 - Note which staff need high-level training on the specifics of the new coding system and which ones require only an overview and training on practice procedures. It's possible that overtime costs for training may need to be considered a factor in the transition
 - Don't forget to account for physician training! If the physicians don't properly code their patient encounters, revenues drop and the rest of the practice cannot function effectively

- Overall budget

- Training for staff and physicians
- Loss of productivity in other tasks
- Software upgrades for various programs and any licensing fees
- Hardware upgrades if your current systems cannot handle upgraded or additional programs
- Material costs (other than technology)
 - Telephone bill increases due to usage
 - Paper and toner costs for reprinted superbills, requisitions
 - Wear and tear on printers and faxes

The transition has the potential to be costly!

Step 3: Act

- Take steps to implement the changes
 - Contact each of the needed vendors and discuss their readiness for 5010 and ICD10
 - Can their systems accommodate the changes?
 - Do they need to upgrade any of the software or hardware that your offices uses?
 - How long will an upgrade take and will it interrupt your office functions for a time period?
 - Is there a cost for any upgrades?
 - When can testing of the system be completed?
 - Start working with each vendor as soon as possible, and make sure that your practice or facility is a priority for them

- Review each of your insurance payer contracts and fee schedules
 - Look for any reimbursement amounts that are dependant on specific codes
 - Contact them immediately with any findings and get any proposed resolutions in writing
 - Consider outside help in this area- let the experts do what they do best

- Contact each insurance company and ask about their readiness for 5010 and ICD 10
 - Payer specific software
 - Mapping ICD 9 to 10
 - When can testing start?

- Begin training of your staff as early as possible during this process
 - Make sure all staff understand why the new 5010 version and the ICD 10 codes are being implemented
 - Detail the training that will be provided to staff and make sure that they understand their responsibilities
 - Explain how the changes will impact their work tasks and any new policies or procedures that will be created
- Prioritize training of departments
 - Physicians and Other Providers
 - Billing and Check-out Staff (Coders)
 - Administration (Check-in, Medical Records and Referrals)
 - Clinical

- Start making adjustments to any paperwork or forms that need to be changed
 - Superbills or patient encounter forms
 - Lab or test requisitions
 - Inter-office referral forms (payers should provide you with any payer-specific forms that require changes)
- Once the confusion begins to clear and new paperwork and processes appear to be working well, formalize the any procedures or policies and place them in your practice or facility Operating Procedures Manual

Step 4: Implement

Time to go live!

- Anticipate snags the first few weeks
 - There will be slow-downs in patient flow and staff tasks
 - There will be problems with transmitting claims, denials and receiving electronic funds
 - There will be frustration!

- Schedule more time for tasks, even if this means not packing your patient schedule as tight as possible for Week One of the go-live date
- Schedule more staff if needed to accommodate for slow downs and the extra time it may take to get through the day
- Acknowledge staff frustration
 - Managers at the ready to diffuse tension
 - Schedule a reward for a job well done!
- The gains made in competence and efficiency will make up for a temporary drop in revenue

- Ongoing tasks
 - Quality checks on all electronic transactions.
Especially claims transmissions and EFT
 - Monitor payer correspondence for changes in reimbursement or fees due to changes in coding
 - Ongoing revision of diagnosis codes requiring prior authorizations or other actions for approval. There may be many of these adjustments
 - Continued staff training on new procedures and codes

- Revise as needed- if something isn't working, fix it!

Remember

- Making the transition to 5010 and ICD 10 will take directed, step-by-step action
- Create a team, create a plan, create accountability, and take the action to get where you need to be

Q & A

Centers for Medicare and
Medicaid Services

<http://www.cms.gov/ICD10/>

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