GETTING READY FOR ICD-10 CHANGES
By Richard Pinson, MD, FACP

Coding involves the conversion of diagnoses, procedures and other medical services and information into sequences of numbers and/or letters. Beginning Oct. 1, 2013, those numbers and letters are scheduled to change. The current ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) will be replaced by the ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) for diagnostic reporting of diseases and conditions.

Since 1978, ICD-9-CM has been the coding classification system used to assign diagnostic codes for all health care claims. Hospitals also use ICD-9-CM to bill facility fees for procedures and other services. The procedural section of ICD-9-CM will be replaced by a new ICD-10-PCS (Procedural Coding System). The American Medical Association’s CPT-4 (Current Procedural Terminology, Fourth Edition) will continue to be the system for coding and billing of professional services and procedures by physicians.

ICD-10 has 68,000 diagnosis codes, compared with 13,500 in ICD-9, composed of three to seven alpha-numeric characters rather than ICD-9’s three to five characters.

Any new coding system requires some time to learn. However, coding specialists should find ICD-10 to be much more systematic and intuitive than ICD-9. ICD-10 retains the same structural format of the earlier edition and has numerous “default” codes—just like ICD-9—for conditions that are not precisely described (“unspecified”). The Official Coding Guidelines for ICD-10 also have only a few changes from the current instructions.

The accuracy and precision of documentation needed from hospitalists under the current ICD-9 system should not change much when ICD-10 takes effect. Those who document well today should fare well under ICD-10; those who don’t will still need to make improvements. The clinical terminology required from physicians will be essentially the same.

The Centers for Medicare & Medicaid Services (CMS) intended that a patient would be assigned to the same hospital diagnosis-related group (DRG) regardless of whether ICD-9 or ICD-10 was used. CMS achieved this goal with greater than 99% accuracy, and essentially all significant comorbid conditions that affect DRG assignment as CCs (comorbidities/complications) and MCCs (major CCs) have been preserved and highly correlated. One notable exception is hypertension—there is no identification of severity in ICD-10, although this could be revised before the implementation date.

The similarities should be reassuring, but preparation is still needed. Selection of efficient and user-friendly software needs to begin now. Effective electronic transmission and processing of claims should be verified and tested with payors. CMS recommends that coders begin ICD-10 training approximately six months before Oct. 1, 2013. Coding personnel should practice coding current medical records based on samples of the most frequent diagnoses submitted and should look for any unexpected documentation requirements.

In summary, coding professionals may experience some initial challenges, but ICD-10 is intended to be more intuitive, systematic and logical. Although physician documentation requirements will be little changed, documentation proficiency remains an essential skill for hospitalists to ensure accurate coding and billing for professional services and for the hospital. The time for preparation is now.

Editor’s note: On Nov. 15, 2011, the American Medical Association’s (AMA) House of Delegates passed a resolution at its 2011 Interim Meeting asking the AMA to “vigorously work to stop the implementation of ICD-10.” No further information was available at press time.

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