

Eye See Dee Who?

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Health Information Management

ICD-10-CM

What is it?

Perhaps you've heard of ICD-10 CM (International Classification of Diseases, 10th Revision, Clinical Modification). Perhaps you've heard of it and, in an avoidance strategy, tucked it away as something to worry about in a year or two, much closer to the October 2013 date of implementation. The objective of this article is to provide you with a better understanding of ICD-10 (I-10), how it will impact you, and what can be done now to better prepare for this mammoth change, which is being compared in complexity to Y2K planning and the implementation of HIPAA. This will be one of several ongoing articles on ICD-10 CM between now and October 2013.

ICD-10-CM and ICD-10 PCS are updated versions of ICD-9CM (I-9), which has been in existence for over 30 years. **ICD-10 CM** is a major revision to the **diagnoses section** of ICD-9 CM. **ICD-10 PCS** is a rewrite of the **procedure section** of ICD-9-CM. Because CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) coding will continue to be used for coding procedures and encounters in the outpatient setting, physicians don't need to concern themselves with ICD-10 PCS - a small consolation. Interestingly, I-10 has been in existence for about 15 years and was adopted in the United Kingdom in 1995, France in 1997, Australia in 1998, and Canada in 2001. From an implementation perspective, this is good news for us as many of the issues related to data conversion from ICD-9 to ICD-10 have already been worked out. I-10 is mandated to replace I-9 on October 1, 2013.

Why change?

We've outgrown I-9. This new classification system provides significantly greater detailed information and the ability to expand as advances in clinical medicine occur. I-10 has about 5 times the number of diagnoses codes found in I-9. I-10 codes are alphanumeric, as opposed to the primarily numeric I - 9 codes. I - 10 codes contain up to 7 characters, as opposed to the 5 characters in I - 9. I-9 is unable to accommodate the additional codes resulting from advances that have occurred in medicine over the past 30 years.

Some changes to look for:

- + There are added code extensions for injuries and external causes of injuries
- + There are expansions of codes for laterality
- + Expect combination codes for diagnosis and symptoms
- + Many codes replacing one code: for example, right now there is one code for angioplasty. With I-10 there will be 854 code choices specifying body part, approach, and device.

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How this will impact you?

Not only does the new code set include five times as many codes as the ICD-9 code set, the different arrangement of codes will require more documentation, revised forms, retraining of staff and physicians, and changes to software and other information technology systems. Changes in reimbursement patterns may also result from the increased specificity of the new code set. Key topics for physician practices to start discussing now include re-writing of superbills, preparing for enhanced documentation, making sure your software systems can adapt and accept the new code formats, and working out any existing contracts with insurance companies that have clauses related to specific I-9 codes. Provider organizations, specifically acute care hospitals, will need to train clinicians to improve their documentation practices so medical documentation contains the details needed to support the higher level of specificity in ICD-10 codes.

What should you do now?

1. Look to your professional organizations for articles or advice on I-10. Don't waste time reading about why conversion to I-10 is a huge mistake – it's too late for that.
2. Identify all systems or processes that use I-9 codes – it's not too early to start talking to IS vendors.
3. Look at current insurance contracts and review existing medical policies related to I-9. Are these contracts tied to reimbursement or a particular diagnosis?
4. Start to think about training. Physicians, coders, billing staff, administrative staff and clinical staff will all need some amount of training. Training in specialty practices may be less complex as focus can occur in a subset of codes. Don't train too soon though. An aggressive training program commencing no sooner than April 1, 2013 is suggested.
5. Don't convert superbills until 6-12 months pre go live, but in the meantime, review them now and remove rarely used codes. You'll need a much larger superbill – perhaps it's time to think electronic.
6. Don't underestimate the complexity of this conversion and the cost.
7. Don't underestimate the amount of training that will need to be done.

How much is this going to cost me?

We don't know. There are articles on the web that cite massive amounts of money that will be required by each practice to be ready for 2013...and just as many articles refuting these allegations. Some claim that primary care physicians will have the most challenging issues and expenses related to conversion. We do know that the following areas will require resources:

- + Training
- + Forms redesign, including superbills
- + System changes
- + Reduced staff productivity
- + Additional documentation time that will be required by physicians

What's next?

Stay tuned for additional articles. We'll take it chapter by chapter to provide highlights of the major changes. As we get closer to implementation, the Health Information Management Department will be available to provide additional educational sessions for you.

Start planning now before your anxiety, 300.20 in I-9, becomes F41.8 in I-10.

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WE'RE ON THE WEB
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TGH Welcomes our new Physicians

The physicians below were added to TGH staff August 31st

Salvador Bruno, MD	Hematology-Oncology
George F. Cohen, MD	Dermatology
Gitika Dham, MD	Internal Medicine
Alfred T. Frontera, MD	Neurology
James M. Galas, MD	Pediatrics
Richard J. Gonzalez, MD	General Surgery
Raquel G. Hernandez, MD, MPH	Pediatrics
Richard C. Karl, MD	General Surgery
Siva K. Kumar, MD	Cardiology
Christopher McGuire, MD	Emergency Medicine
Katherine D. Nardell, MD	Pediatrics
Richard G. Picciocca, MD	General Surgery
Gilbert A. Postler, MD	Cardiology
Jeremy M. Ringewald, MD	Pediatrics
Shalin R. Shah, DO	Hematology-Oncology
Sabina Saddiqi, MD	Anesthesiology
William N. Upshaw, MD	Psychiatry

KUDOS TO OUR PHYSICIANS!

Congratulations to the following physicians who were recognized by their patients in the form of personal letters to TGH leadership.

Dr. Selim Benbadis & Dr. Fernando Vale (See page 3),
Also Dr. Marc Stauffer, and Dr. Christiano Caldeira



This newsletter is produced by Tampa General Hospital's Quality Improvement Department. All comments, responses or suggestions are welcome and should be directed to:

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