

# A McKesson Perspective: ICD-10-CM/PCS

## Its Far-Reaching Effect on the Healthcare Industry

### Executive Overview

While many healthcare organizations are focused on qualifying for American Recovery & Reinvestment Act (ARRA) incentive funds to adopt electronic health records (EHRs) and achieve meaningful use, there is another large reform initiative that is not getting its due attention. Based on a code set already in use by other developed countries around the world, the United States government is mandating the use of ICD-10 code sets for diagnoses and procedures starting Oct. 1, 2013. To transition to ICD-10, organizations must also migrate from existing Electronic Data Interchange (EDI) transaction standards to the new ANSI X.12 version 5010.

The code sets are expanding from an approximate total of 20,000 in ICD-9 to more than 155,000 in ICD-10 — almost an eight-fold increase. Because of the magnitude of the difference in the number of codes in the sets, for many codes there will be no “crosswalks” with a one-to-one match. The EDI transactions associated with the claims cycle will need to be revised and tested. Healthcare providers will be affected in virtually all aspects of their business: financial and clinical, operational and organizational.

ICD-10's impact will be disruptive in the short term, but positive over the longer term. The expansion will benefit the delivery of care by indicating more precisely the diagnosis, and will better match the payment for care to the care delivered. In time, it will promote greater efficiencies in care documentation and claims processing. The greater detail will provide organizations with improved business intelligence of care delivery and operations.

Whether you are a provider of care or a payer that reimburses for care, now is the time to start preparing your organization for the conversion.

You need to educate almost everyone in your organization, including:

- Coders on the expanded code set, medical terminology and anatomy.
- Physicians on the specificity required for clinical documentation to support ICD-10 coding. Some adjustment to documentation practices and templates will be required.
- Physician office managers so they can assess the impact to the office workflow, optimize practice coding and evaluate the impact to the Super Bill.
- Staff members that assign diagnosis or procedure codes whether at admitting, order entry or discharge.

*ICD-10 codes are the foundation for reimbursement and much of your business analytics, while EDI is the transport tool for your claims. Not being ready for the compliance dates will dramatically affect your business.*

- Financial planning and administrative staff to assist in financial impact assessments and in revising performance management and decision support analytics.
- Clinical quality and process improvement teams to incorporate new codes in reporting and to take advantage of increased clinical data for enterprise intelligence.
- Payers on the impact to contracts, eligibility, medical policy, claims code auditing and reimbursement systems.

In addition to providing organization-wide education, you also need to assess the impact to IT systems. You should work with your IT vendors to ensure you will have the ICD-10 version of their software in time to make the transition.

ICD-10 codes are the foundation for reimbursement and much of your business analytics, while EDI is the transport tool for your claims. Not being ready for the compliance dates will dramatically affect your business. The Centers for Medicare & Medicaid Services (CMS) will not accept 4010 EDI transactions starting Jan. 1, 2012 and claims without ICD-10 coding starting Oct. 1, 2013. CMS has been clear that they will be ready. McKesson wants you to be ready too.

Just as McKesson supported its customers with the technical conversion requirements of Y2K and HIPAA, we can help you address the conversion to ICD-10 by providing:

- Services, such as a readiness assessment and clinical documentation reviews, to aid in your implementation process.
- Education to help your administration and users understand the scope of ICD-10.

On the following pages are additional details on the conversion and its impact on healthcare providers. McKesson offers readiness services to help you prepare for ICD-10.

## White Paper on Implementation of ICD-10 Code Set

### *Background*

### *Why the Update?*

### *The Impact of ICD-10-CM/PCS on the Industry*

### *McKesson ICD-10/5010 Services*

### *Background*

Under the Health Insurance Portability and Accountability Act (HIPAA), the Secretary of the Department of Health & Human Services (HHS) is required to adopt transaction standards and data elements for the electronic exchange of health information for certain healthcare transactions. The Secretary is also required to review the HIPAA standards and adopt modifications as appropriate, but not more frequently than once every 12 months. This requirement includes ensuring the routine maintenance, testing, enhancement and expansion of code sets.

The International Classification of Diseases, 9th edition, Clinical Modification (ICD-9-CM) is the clinical code set currently used to report diagnoses and procedures in healthcare encounters. The ICD-9 code set is based on the World Health Organization's (WHO) International Classification of Diseases.

- ICD-9-CM Volumes 1 and 2 are created and maintained by the National Center for Health Statistics to report diagnosis codes.
- Volume 3 of ICD-9-CM, which contains the procedure codes, is developed and maintained by the Centers for Medicare & Medicaid Services (CMS) Coordination and Maintenance Committee.

On Aug. 22, 2008, HHS proposed the replacement of the ICD-9-CM code set with ICD-10-CM and ICD-10-PCS. After a comment period, HHS issued a final rule for concurrent implementation of the International Classification of Diseases 10th revision on Jan. 16, 2009:

- Clinical Modification (ICD-10-CM) for diagnosis coding.
  - Procedure Coding System (ICD-10-PCS) for inpatient hospital procedure coding.
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The new code sets replace the current ICD-9-CM Volumes 1, 2 and 3. The effective date of this regulation was Mar. 17, 2009, with a compliance date of Oct. 1, 2013.

### *Why the Update?*

#### **The Constraints of ICD-9**

Over time, the use of ICD-9 coded data has expanded beyond its originally intended scope. Today, the codes are used by different types of data collection and reporting systems to support the needs of a variety of stakeholders. However, the code set lacks the specificity to fully describe a disease state or procedure.

Because the ICD-9 system has limited space for adding new codes due to its structure, multiple codes are often required to accurately describe certain procedures. And due to the space limitations, codes have been assigned to inappropriate chapters, adding confusion to the coding process.

#### **The Benefits of the ICD-10 Expanded Code Set**

The ICD-10 code set expands the field length of the code. The expansion enables the addition of codes to support advances in medicine and provide greater specificity in clinical documentation. The codes differentiate body parts, surgical approaches and devices used. Injuries are grouped by body part rather than category of injury.

- ICD-10-CM contains approximately 68,000 diagnosis codes. The expanded codes provide the ability to capture specifics such as trimester in pregnancy, external causes of injury, ambulatory care conditions and post-procedural disorders.
- ICD-10-PCS contains approximately 87,000 procedure codes. The first character shows the type of procedure by clinical specialty, and each subsequent character has a specific function that may change depending on the service.

In the final rule, HHS notes that the benefits of ICD-10-CM and PCS will become apparent the year after the code set has been implemented. Benefits include the following:

- New and more complex procedures will be assigned codes that accurately describe the procedure. The specificity will lead to more accurate payment, in contrast to the current system where new procedures are often inappropriately grouped.

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- The specificity and detail in ICD-10-PCS will reduce the need for claim attachments. It is expected to decrease the number of claims that are rejected due to lack of information needed for adjudication.
- The specificity of ICD-10 is expected to reduce the number of miscoded claims that result from the ambiguity of the ICD-9 codes.
- The code set will enable more comprehensive quality reporting and improve disease management through the sharing of disease and morbidity data. In addition, the increased clinical detail will provide more precise disease/condition definitions that can be analyzed for planning, monitoring and improvement efforts.
- More precise business intelligence will be available to measure and improve resource utilization, patient safety, clinical research, contract modeling and management, disease management, and operational and strategic planning.
- Shared global code sets provide expanded opportunities for international benchmarking and best practices. The shared code sets also will improve the ability to track international health threats and enable clinical data comparability with other countries.
- It is anticipated that the transition to ICD-10 will provide the detailed data to support later-stage ARRA's meaningful use objectives, quality measures and emerging care delivery models.

### *The Impact of ICD-10-CM/PCS on the Industry*

The transition to ICD-10 will have a wide-ranging effect on most healthcare entities, including providers (hospitals, practices and homecare), payers, medical billing and coding companies, clearinghouses and IT vendors.

#### **Provider Organizations**

The change to ICD-10 is expected to have wide-ranging impact on provider operations, including staff education, possible staff augmentation, updating of IT systems, assessment of clinician workflow processes, and analysis of cash flow and budget impact.

For providers, the changes will require:

### ***Project Planning***

- **Get Buy-in and Budget from Leadership:** Educate senior leaders on the impact and importance of ICD-10 readiness. Maintain ongoing communications about the project and its status. Get buy-in for expenses related to the transition, such as training and system upgrades.
- **Create a Multidisciplinary Task Force:** Create an internal task force that represents the departments and constituents affected by the code set change. Include the Health Information Management department, ancillary departments, the information systems team, business office, physicians and other clinicians.

*Identify policies, procedures and authority for ensuring compliance with appropriate coding and the detailed clinical documentation required to submit ICD-10 claims.*

The primary responsibility of this team is to provide cross-functional leadership, assess the business impact and opportunities, develop and coordinate an organization-wide roadmap, track and measure progress, and provide an information forum for routine and targeted communication.

- **Create a Governance Structure:** Identify policies, procedures and authority for ensuring compliance with appropriate coding and the detailed clinical documentation required to submit ICD-10 claims. A well-defined governance structure will avoid coder workflow disruption due to lack of compliance by clinicians in providing necessary documentation details.

The governance team should primarily consist of senior representatives from the medical and nursing staff, Finance, IT, Health Information Management and the Business Office. The governance team serves two purposes:

- The team works with the multidisciplinary task force to provide the necessary framework for interdisciplinary review and to mitigate business or care delivery risks associated with the transition project.
- The governance team evaluates current policies and procedures that support the revenue cycle. The team assesses those that require revision and creates new ones to address changes necessary to support the new workflows.

With policies for documentation and coding practices, consequences/ action plans published, and authority established, the team will drive compliance and better overall performance post transition. Without a governance structure, you risk extended disruptions, staff frustration and fatigue, and poorer than anticipated financial performance.

- **Establish a project plan and timeline:** In your planning, address activities required to meet the 2013 deadline, such as a readiness assessment, coder training, physician training and information system upgrades.
- **Create a Communications Plan:** Educate the entire organization on the impact of the change on policies and procedures. Stress the importance of the project since it affects reimbursement and accounts receivables.
  - Provide ongoing status updates to maintain focus on the project and upcoming initiatives that require staff involvement.
  - Provide regular updates to senior leaders and those most directly affected by the changes, such as coders, clinicians and physicians.

#### ***Education for Coders and Physicians***

- **Physicians:** Due to the precise nature of the codes, physicians will need to provide comprehensive documentation so that coders can select the correct code. Physicians will need training on the documentation detail required to support ICD-10 coding related to their specialty or practice. Proper documentation will help ensure accurate and speedy reimbursement. At the same time, assess whether documentation templates need to be revised.
- **Coders:** Coders will need training on the expanded code set. There are estimates it may take from one to two weeks of training for most professional coders. An AHIMA “ICD-10-CM Field Testing Project” in 2003 estimated approximately 50 hours for training experienced, professional coders. In addition, the new code set will require increased coder knowledge of medical procedures and anatomy due to the clinical specificity of the new code sets. Anatomy refresher courses for all coders are highly recommended.
- **Timing:** Ensure training is early enough to develop proficiency without being so far in advance that knowledge is lost. Having a dual coding environment available will enable staff to practice in the new code set.

*Analyze your staff's knowledge of medical procedures and anatomy, which are important to selecting the right ICD-10 code.*

### ***Resource Management and Assessment***

- **Assess Your Need for Additional Coding Staff:** In addition to the loss of productivity during the training and testing phase, CMS and AHIMA have estimated an anticipated impact to coder productivity for three to six months after implementation of the new code set.
- **Assess Staff Knowledge:** Evaluate whether you need additional experienced coding staff. Analyze your staff's knowledge of medical procedures and anatomy, which are important to selecting the right ICD-10 code. Coders may need training in these areas.
- **Outsourcing of Coding:** As you assess the impact to your organization, you may want to consider outsourcing coding during the preparatory stage. Outsourcing will allow for just-in-time training and reduce the burden of the transition on staff.
- **Don't Wait to Hire Experienced Coders:** Hospitals, payers, independent practices and associated hospital specialty groups will all be reviewing current staffing levels and considering staff augmentation or outsourcing. There will be competition for qualified, certified coders with the anatomical knowledge needed to select the correct code in the new code set. If you are considering temporary or permanent staff increases, finalize your plans soon.

### ***Support for Dual Coding Requirements***

- **Dual Coding Prior to the Cut-over Date:** While you cannot submit claims with ICD-10 codes prior to the cut-over date of Oct. 1, 2013, you will want to allow for dual coding in a production environment some months prior to the date. Dual coding provides your staff with practical experience to reinforce their training. It also enables you to identify and address problem areas, including your new governance policies, before they impact cash flow. How soon is dependent on your readiness.
- **Discharge Date-determined Code Set:** The discharge/through dates determine the code set to be used for a claim. To ensure claims are not returned as unable to be processed, providers should ensure:
  - Claims with dates of service or dates of discharge/through dates on or after October 1, 2013, use ICD-10 codes.
  - Claims with dates of service or dates of discharge/through dates prior to October 1, 2013, are billed with ICD-9 diagnosis codes.

- Split claim situations require that providers split the claim so all ICD-9 codes are on one claim and all ICD-10 codes are on another claim. One claim cannot have both ICD-9 and ICD-10 codes.
- An anesthesia claim for procedures that begin on September 30, 2013 but end on October 1, 2013 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the From and Through date.

Medicare contractors need to be able to continue to process ICD-9 codes for dates of service prior to October 1, 2013, including as needed for redeterminations/appeal decisions on claims that have dates of service prior to October 1, 2013.

- **Non-HIPAA-covered Organizations:** These organizations are not required to move to ICD-10 (such as workers compensation and automobile insurance companies). While they may move to the new code set, your organization should anticipate creating and processing ICD-9 transactions for these organizations at the same time as ICD-10 for HIPAA-covered organizations.

### ***Aggressive Management of the Revenue Cycle***

- **Analyze Rejected and Unbilled Claims:** Current coding challenges will multiply with the introduction of ICD-10. By starting now, you can use your transition time to mitigate existing problems while minimizing the introduction of new ones.
- Focus on optimizing each phase of the revenue cycle, but especially denied and not-final-billed claims. Evaluate the reasons behind reimbursement delays. Analysis of denials and delays may uncover the need for additional staff or training. Work with individual coders on productivity and with physicians on meeting documentation requirements
- **Service Line Assessments:** Review the ICD-9 and equivalent ICD-10 coding that supports your key service lines and your most commonly assigned and highly reimbursed DRGs. Ensure that you have training plans for these essential codes and have addressed clinical documentation requirements. The government is providing General Equivalency Mappings (GEMs) to help in the development of code mapping tools. When there are multiple ICD-10 codes that replace the ICD-9 code, some of the industry-developed mapping tools can provide guidance by displaying the possible or most appropriate ICD-10 code options.

*Changes to payer systems are also far-reaching — from benefit definition and provider contracts to claims adjudication and coder education.*

- **Project the Impact to Cash Flow:** Develop a cash management strategy to ensure you have enough cash on hand to cover the transition period. During the transition, plan for a higher percentage of rejected claims due to inadequate documentation or inappropriate coding.
- Some payers are considering using a translation process that will reverse code ICD-10 submissions to ICD-9 codes for the calculation of the MS-DRG. This reverse mapping can affect reimbursement. Understanding your payer's approach will help you plan accordingly.

#### ***Information System Management***

- **Identify All Systems Affected by 5010 and/or ICD-10:** Develop a roadmap based on their planned release dates and schedule your slots for implementation. Make sure your systems are upgraded and tested well before your organization's planned cut-over date.
- **Schedule Transaction Testing:** Schedule clearinghouse testing of 5010 -related transactions with your payers. The testing period begins Jan. 1, 2011.
- **ICD-10 Readiness of Foundational Systems:** Your health information management and billing systems are foundational to your revenue cycle and the ICD-10 transition.
- **Dual Code Support:** Ensure your systems can support simultaneous coding of both code sets during the transition period and the early cut over.
- **Understand Release Plan Impacts:** Understand your vendors' release plans for 5010 and ICD-10. Will there be multiple releases and service packs to plan for? Factor those into your schedule. The CMS ICD-10 Grouper comes out Oct. 2012. Your vendor solutions that are affected by Grouper changes will need to provide one more update prior to go live. Make sure that this final update is in your plan and fits into your cut-over date.
- **Schedule Release Upgrades:** Schedule your release upgrades as soon as possible. Every affected vendor has to upgrade its customer base. Map your upgrade process and proactively budget and schedule upgrade slots with your vendors.

### ***Payer Organizations***

Changes to payer systems are also far-reaching — from benefit definition and provider contracts to claims adjudication and coder education. The ICD-10 changes are in addition to the extensive changes emanating from the Patient Protection and Affordable Care Act.

Mapping of code sets is merely the first step in the transition process from ICD-9 to ICD-10. Long-term success of payer organizations is reliant upon having a robust and clinically sound medical policy to handle the expanded clinical detail inherent in ICD-10. The changes will drive updates to the information systems that drive: contracting, eligibility and benefit determination, reimbursement policy, notifications such as Evidence of Benefit/Evidence of Coverage (EOBs/EOCs), utilization reviews, fraud and abuse detection, claim adjudication and claim code edits, statistical analysis, pricing and data abstracts.

For payers, the changes will require:

- Reviewing all systems that use an ICD-9 code or a 4010 format. For example, CPT and HCPCS codes, which are based on the ICD codes, have become de-facto tools that support the reimbursement structure of the US health system. Payers also must assess the impact to their systems of the changes to these codes and develop operational action plans.
- Reviewing and addressing medical policy. One approach is to evaluate the most frequently encountered diagnoses/procedures or those with the highest fiscal impact first. Once medical policy is addressed, the remainder of the systems can be updated accordingly (contracting, utilization, benefit design, and so on).
- Updating systems for both ICD-10 and 5010 changes. Since both changes are intertwined, payers may want to use a “touch once — update both” approach. This approach means payers should take one pass through their business process software to identify changes for both, and then update for 5010 and ICD-10 at the same time.
- Since these systems are integral to the stability of the payer organization functionality, payers may be advised to use internal resources that are most familiar with the systems rather than contractors to make the changes.
- While payers will eventually support the MS-DRG Grouper for ICD-10 codes, it is possible for a time that payers will leverage parts of their existing solutions. At this point, it is not clear which approach will be most prevalent, but some payers will opt to support the

mapping of ICD-10 codes to ICD-9 for purposes of DRG calculation and reimbursement within their claims processing system.

- Ensuring the ability to support both code sets for a period of time. Like providers, HIPAA-compliant payers recognize the requirement to handle both ICD-9 and ICD-10 codes for a transition period.
- Evaluating the need for additional staffing to handle provider questions and customer service demands increased denials during code set cut over.
- Testing claims transactions with customers directly or through the clearinghouse. The testing period begins Jan. 01, 2011.

*Claims clearinghouses must update their systems to accept and transmit the new transactions with the ICD-10 codes.*

#### **Claims Clearinghouses**

Claims clearinghouses must update their systems to accept and transmit the new transactions with the ICD-10 codes. The transaction format has been updated from 4010A to a 5010 format to accommodate the expanded field length of the ICD-10 codes. Clearinghouses have to attain two levels of compliance:

- Level 1 Compliance — Demonstrate internal readiness to send and receive 5010 transactions by Dec. 31, 2010
- Level 2 Compliance — Complete 5010 testing with trading partners with a fully production-ready system by Dec. 31, 2011

On Jan. 1, 2012, clearinghouses must be able to handle the 5010 transactions for live transmission.

#### **Health IT Vendors**

Vendors must design, develop and test system changes, and they will need to establish a plan to roll out those changes to their customers. These changes may require customers to upgrade their software to the latest version. Vendors will need to modify and test their interfaces to third-party systems when the interfaces communicate code data. Moreover, vendors believe it will be necessary to provide dual support for ICD-9 and ICD-10 code sets for a period of time.

Vendors that provide temporary and outsourced coding services must ensure their coders have received training on the new code sets. In addition, with the greater clinical specificity of the new code sets, coders will need deeper clinical and anatomical knowledge to select the appropriate codes. They will also need to address clinician

documentation requirements for those practices and hospitals that they support.

### *McKesson ICD-10/5010 Services*

#### **McKesson's Proactive Leadership**

McKesson has taken several steps in preparation for the transition to the ICD-10 code sets and 5010 transactions.

- In mid-2008, a task force was established in our Regulatory and Compliance Department, part of McKesson's Law Department, to begin the process of working with each product group for ICD-10-CM/PCS implementation.
- McKesson's product groups have been assessing, planning and developing changes within the products since 2008.
- McKesson continues to take a leadership role in moving forward with ICD-10 implementation and participating in various industry organizations such as WEDI (Workgroup for Electronic Data Interchange)

#### **McKesson Services for ICD-10**

McKesson provides services and support to aid in your implementation and process re-engineering needs. McKesson's Revenue Cycle group offers a comprehensive series of service tracks to assist organizations in their pursuit of ICD-10 readiness. The tracks build upon each other and enable you to decide just how much assistance you need.

- Track 1 – Readiness assessment: Assess the readiness of your technology, process and operations. The assessment looks at everything from coding and documentation to custom interfaces, training requirements and financial implications. Incorporated in this track is a review of the most used ICD-9 codes and ICD-10 mappings.
  - Track 2 – Roadmap Development: Develop a process and operations roadmap to guide your organization to compliance.
  - Track 3 – Implementation and Risk Management: Implement systems, technology, workflows, process, risk management tools and support. We will augment your staff with industry experts and project leadership to enable you to focus on the big picture while we take care of the details.
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*The assessment looks at everything from coding and documentation to custom interfaces, training requirements and financial implications.*

- For more information on McKesson's ICD-10 Preparation Service Tracks, please e-mail [ICD-10PREP@mckesson.com](mailto:ICD-10PREP@mckesson.com).
- McKesson's Revenue Management Solutions group provides coding services to hospital-based and independent practice physicians. We will have all operational requirements met prior to the deadlines as well as the supporting systems and interfaces fully tested.

The group offers the services of more than 500 certified coders for multiple specialties. The specialty-specific, certified coders are already highly proficient in human anatomy, medical terminology, existing coding disciplines, and ICD-10 basics. The required highly advanced human anatomy and medical terminology education will be provided to all medical coders early in 2012. Intensive ICD-10 coder training will be delivered in late 2012 and early 2013, well before the Oct. 1, 2013 cut-over date. As part of our service, RMS managers and coders will train physicians on the new documentation and coding requirements.

## **McKesson Provider Technologies**

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