ICD-10 Readiness

Vitera Webinar FAQs

1. What type of training will providers and staff need for the ICD-10 transition?

   AHIMA recommends training begin no more than six months before the compliance deadline. Training varies for different organizations, but is projected to take 16 hours for coders and 50 hours for inpatient coders. For example, physician practice coders will need to learn ICD-10 diagnosis coding only, while hospital coders will need to learn both ICD-10 diagnosis and ICD-10 inpatient procedure coding.

   Look for specialty-specific ICD-10 training offered by specialty societies and other professional organizations. Take into account that ICD-10 coding training will be integrated into the CEUs that certified coders must take to maintain their credentials.

   ICD-10 resources and training materials will be available through CMS, software systems/vendors and professional associations and societies. Visit www.cms.gov/ICD10 regularly throughout the course of the transition to access the latest information on training opportunities. (Source CMS)


2. When should our office begin training?

   The question of when to deliver training does not have a one-size-fits-all answer. Getting training too early is not recommended as it may need to be repeated; if you wait too long, individuals may not have enough time to work with the codes and become proficient before the implementation date.

   Implementation training is available now and should be completed by the first part of 2013. This type of training is ideal for those responsible for their organization's implementation of ICD-10 and for coders who want to understand the full implementation process.
Anatomy and pathophysiology training is also available now and should be completed by the first part of 2013. Due to the clinical nature of ICD-10-CM, it is recommended that those without a very strong understanding of anatomy and/or physiology take a refresher course.

General ICD-10-CM code set training should be taken in 2013. This training will cover the complete guidelines and should include coding exercises. This training will also prepare coders for the ICD-10 Proficiency Assessment. Specialty ICD-10 code set training should be completed in 2014. Specialty training is for those that want more detailed training for a particular specialty or more advanced multi-specialty training.

It may seem like Oct. 1, 2014 is far away, but with the magnitude of work that needs to be completed, advance planning and education are crucial for success. CMS provides great tools on their website including Implementation Timelines and implementation guides for small-medium and large practices.


3. Should I wait until I have training and learn the specifics of my specialty before approaching the doctors about changes they need to make in their documentation? I am getting resistance to ICD-10 already and feel some of my doctors want to see something in writing showing them the changes they need to make.

ICD-10 changes affect most of your office staff and can include modifications to the workflow for many of them. It is important to develop a plan that first identifies where you are currently using ICD-9 in your office today. This will help you recognize all of the places where ICD-10 will influence your staff as they work.

Most office managers won’t be able to give their providers a list of the old codes with a crosswalk to the new codes – it requires more skill and thought from the providers than that. The key to successful ICD-10 compliance is focusing on the necessary clinical documentation that ICD-10 will require. It is imperative to get this information to your providers in small bits over a long period of time. In the past, providers have been cautioned to provide details in the encounter/visit notes. In ICD-10, this becomes much more critical.
The myth that the clinical documentation portion will overwhelm physicians is grossly exaggerated. Most changes or additions are only a matter of one word or two, or perhaps a sentence. But to wait until the compliance date is approaching will be too late. Providers who want to experience the least amount of financial impact to their practice will realize the importance of investing in training and practicing what they learn. Like anything new, repetition makes it easy.


4. What is the average cost to train the coding staff?

CMS and other Medical Societies and Groups have estimated the costs of training staff and those numbers have varied based on the type of organization. Hospital and large organizations that are paid based on DRGs (diagnosis codes) are budgeting the largest amount of money to training. Those numbers are generally around $10,000 per provider. However, the average smaller physician practices should budget or anticipate around $2,400 per provider.


5. How do I obtain the code set to import into my Practice Management and EHR systems?

Vitera Customers will not need to purchase ICD-10 codes. They will receive ICD-10 codes with their ICD-10 software update.

If you do not have Vitera software, you may need to purchase a CD with the new codes and load them into your system or you may need to enter them one by one into your system. Please check with your vendor to see how ICD-10 codes may be provided for your system.
6. **How does the ICD-10 compliance date impact providers that file paper claims?**

   The ICD-10 code set must be used on all (1) claims with dates of service and (2) inpatient claims with a date of discharge on or after the mandated compliance date of October 1, 2014. The method used to submit the claim has no impact on the code set contained on the claim.

   Although ICD-10 does not require an EHR, filing electronic claims can simplify the process. Many practitioners opt for EHR and Practice Management software for this reason, as well as financial incentives (like Meaningful Use), enhanced patient care, improved efficiency and reduced administrative costs.

7. **Will there be changes to the CMS-1500 (“HCFA”) or CMS-1450 (“UB-04”) paper claim forms?**

   Yes to both. The National Uniform Claim Committee (NUCC) has decided to change the CMS-1500 and CMS-1450 paper claim forms to accommodate the use of ICD-10 diagnosis codes. You can find information at www.nucc.org.

   Please check with your vendor to ensure that the new claim form will be formatted for you and your system will be modified to accommodate the new fields. Although most Vitera customers elect to file claims electronically, all Vitera customers will receive the new paper form and the ICD-10 software release including all of the fields necessary to complete the form.

8. **Our practice does not have an EHR. Can we still use a superbill with ICD-10?**

   With the volume of codes increasing exponentially when ICD-10 takes effect in 2014, practices really need to start thinking about how they’ll revamp their superbill in preparation for the new coding system.

   Example: Although there are 33 codes for fractures of the radius in ICD-9, most Orthopedic practices’ superbills generally include only six codes or less. Coding often defaults to one of these codes, even though another of the other 33 codes might be more accurate. Under ICD-10 there are 1,818 codes for fractures of the
radius and there is simply not enough room to include these codes, plus the thousands of other relevant codes, on a standard superbill. ICD-10 codes have much less in the way of general codes and in many instances force the use of very specific choices for a defined condition.

The American Health Information Management Association (AHIMA) converted a superbill from ICD-9-CM to ICD-10-CM to demonstrate what the new form might look like. However, it cautions providers that the sample doesn’t represent an AHIMA endorsement of the use of superbills or of this particular superbill format.


9. I thought HIPAA code set standards only applied to the HIPAA electronic transactions. What if I don’t use the HIPAA electronic transactions?

Technically speaking, the HIPAA standard applies to electronic claim transactions, not paper claims. However, the vast majority of healthcare claims are submitted electronically, except for rare occasions where unusual circumstances may require a provider to compile a paper claim. Payers are expected to require ICD-10 codes be used in other transactions, such as on paper, through a dedicated fax machine or via the phone.

10. How Are Non-Covered Entities Affected?

Non-covered entities are not required to transition to Version 5010 and ICD-10. However, for many organizations, the benefits of adoption far outweigh the challenges. ICD-10 coding will benefit non-covered entities in several ways, including:

- Expanded detail in injury codes, which will help automobile insurance and worker’s compensation programs
- ICD-9 codes will no longer be maintained once ICD-10 has been implemented; the ICD-9 codes will become less useful and resources will be continually harder to obtain
- Use of Version 5010 and ICD-10 facilitates claim filing for coordination of benefits
Implementation of Version 5010 and ICD-10 is consistent with industry standards (source CMS)


11. Will you please show an ICD-9 and ICD-10 side by side example for Otitis Media?

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>382.00 - AC SUPP OTITIS MEDIA NOS</td>
<td>H66.001</td>
<td>Acute suppurative otitis media without spontaneous rupture of ear drum, right ear</td>
<td>Sudden, severe inflammation of middle ear, with pus</td>
</tr>
<tr>
<td></td>
<td>H66.002</td>
<td>Acute suppurative otitis media without spontaneous rupture of ear drum, left ear</td>
<td></td>
</tr>
<tr>
<td></td>
<td>H66.003</td>
<td>Acute suppurative otitis media without spontaneous rupture of ear drum, bilateral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>H66.004</td>
<td>Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, right ear</td>
<td>Based on acute, recurrent or chronic</td>
</tr>
<tr>
<td></td>
<td>H66.005</td>
<td>Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, left ear</td>
<td></td>
</tr>
<tr>
<td></td>
<td>H66.006</td>
<td>Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, bilateral</td>
<td></td>
</tr>
<tr>
<td></td>
<td>H66.007</td>
<td>Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, unspecified ear</td>
<td></td>
</tr>
<tr>
<td></td>
<td>H66.009</td>
<td>Acute suppurative otitis media without spontaneous rupture of ear drum, unspecified ear</td>
<td></td>
</tr>
</tbody>
</table>
12. Will there be ICD-10 codes for procedures like colonoscopy?

No, ICD-10 codes will replace ICD-9 codes. These are diagnosis code and almost all ICD-9 codes have a ICD-10 replacement. Colonoscopy is a CPT code, which is a procedure or service that is delivered to a patient. The diagnosis codes used to support the need for doing a colonoscopy have changed from ICD-9 to ICD-10.

13. If a patient comes in with possible fracture, how do we bill for fracture with specific type of fracture if x-ray has not been done yet?

You always report the signs or symptoms until a definitive diagnosis is documented. For example, the diagnosis code for a possible fractured right wrist and hand due to a crushing injury would be coded as S67.41XA (Crushing injury of right wrist and hand). This would require 2 additional codes - Y92 for the Activity codes and Y93 for the Place of Occurrence codes.

14. How do I code to specify laterality?

Laterality is a significant change in ICD-10-CM. Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral. If no bilateral code is provided and the condition is bilateral, assign separate codes.
for both the left and right side. If the side is not identified in the medical record, assign the code for the unspecified side.

http://www.icd10hub.com/icd-10-glossary.htm

15. Will modifiers still be used, especially with more descriptive diagnosis?

Modifiers are used to provide additional information when appended to a CPT code. Among others, these modifiers describe: the role of the provider, relationship between multiple procedures, increased or decreased services and exceptions to the global period. While ICD-10-CM provides additional information, such as laterality, this information pertains only to the diagnosis. Modifiers will continue to be reported along with CPT and HCPCS codes to provide information necessary to submit a claim for payment.

16. Are there any prerequisites for the transition to ICD-10?

Yes, health care providers and health care clearinghouses must submit claims electronically using the X12 Version 5010 and National Council for Prescription Drug Programs (NCPDP) Version D.0 standards. Version 5010 replaces Version 4010/4010A and is used for electronic health care transactions such as claims submissions, eligibility, and remittance advice. Version 5010 accommodates the ICD-10 codes and must be in place before implementing the new ICD-10 codes.

http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/18_5010D0.html

17. Will the CPT codes change as well?

CPT codes will have some changes just as they do every year. However, there is no major overhaul planned for CPT codes.

18. Will ICD-10-PCS replace CPT codes?

No. ICD-10-PCS will be used to report hospital inpatient procedures only. The Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) will continue to be used to report services and procedures in outpatient and office settings.
19. Are E codes and V codes expanding in ICD-10?

ICD-9 CM has 17 chapters, compared with 21 chapters in ICD-10-CM, which includes separate chapters for the eye and adnexa and the ear. The chapters are subdivided into blocks of three alphanumeric character categories. In addition, the classifications External Cause of Mobility and Mortality and Factors Influencing Health Status and Contact with Health Services (V and E codes in ICD-9-CM) are not considered supplemental classifications in ICD-10-CM and have their own chapter classifications (Chapters 20 and 21).

20. How do you recommend that we conduct testing?

Although many checklists and websites suggest end to end testing, the industry has not yet established a standard method for private practices to do so. A few large hospital chains are attempting to conduct limited testing, but there is no method today for a practice to post charges, send ICD-10 claims to the payer and have them adjudicated to see that they would pass and have the EOB or electronic remit come back and post.

Please note: Medicare stated that they will not be conducting any testing with providers as they are certain that they have no issues. This has made it very easy for other payers to follow suit.

With no way to conduct end to end testing, training staff and laying out a plan are imperative. Here’s what you can do today to prepare:

- Partner with a training company that will review existing charts to see how your providers currently document and code. How they currently document and code under ICD-9 can be used to predict how successful they will be under ICD-10.
- Practice with a coding lab training environment (this doesn’t have to be in your EHR or Practice Management System.) A training environment allows staff to practice documenting and coding ICD-10 in different scenarios. Several companies offer specialty coding labs like this.
- Test additional processes in your system as they become available.
21. When could we start using ICD 10?

The mandated date is Oct. 1, 2014. We don’t expect that anyone will go earlier than that as no one can require ICD-10 codes prior to that date, though they may allow you to use ICD-10 prior to that date. There are some exceptions to this date, such as workers compensation companies who don’t have to accept ICD-10 after Oct. 1, 2014 and there will likely be insurance payers who will not be ready on time.

Vitera Customers will not have to worry about remembering which carriers do or don’t accept ICD-10. They can simply set their systems by payer coding preference and, as of Oct. 1, 2014, the system will code with ICD-10 or ICD-9 for claims processing.

You may want to see how your system will address this issue so you can be prepared.

22. Can we use ICD-10 early?

No. CMS and other payers will not be able to process claims using ICD-10 until the compliance date of October 1, 2014. If you are billing outpatient claims, you will use ICD-9 for dates of service prior to the compliance deadline and ICD-10 for services after the deadline. For inpatient claims, the code set will be based on the discharge date.

23. Is there a Consumer Reports type document to select reputable ICD-10 educational resources?

No, there is no independent entity that is rating ICD-10 educational resources for provider review and use. However, there are a large number of reputable consultants and companies that offer ICD-10 training and consulting services. We have found that CMS, HIMSS, and AHIMA offer outstanding material.

Vitera is currently working on resources and tools that will assist you in your transition to ICD-10 as well.
24. Is it just the AMA that has the ICD-10 draft manual available?
   The AMA has draft manuals, code books and CDs available but they are not the only source for these materials. You can search the internet and check with your coding book vendors to find draft manuals. Additionally, the AAPC has an ICD-10 Draft Manual on their website.


25. Can you recommend any references for training?
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