Ready, Set, 10 Months to Go
How to Get Organized and Be Fearless About ICD-10

Cheryl L. Toth, MBA

"The billing office is handling that," an orthopedic surgeon at a recent reimbursement workshop said. Like many physicians, he was unaware that asking the billing office to handle ICD-10, the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), is like trying to do a crossword puzzle using only the "Down" clues. It is impossible, because half of the information is missing.

"ICD-10 is one of the biggest changes to hit the US healthcare system in decades, with far reaching effects that go beyond claim submission," says Karen Zupko, President, KarenZupko & Associates Inc. "And yet, we find that most orthopedic practices are woefully behind in their planning because they believe that ICD-10 conversion is a billing office task."

But nothing could be further from the truth. ICD-10 requires participation from physicians, managers, surgery schedulers, and the billing team. The new system will be required to prove medical necessity and obtain prior authorization. It is the impetus behind the updated claim form, which is required on April 1, 2014. It will also be the diagnosis language for research study participation. In short, ICD-10 is the new diagnosis language for everything. Abdicate the planning process at your own peril. It is time to get focused and take action.

Unclosed, Unbilled, and Unpaid

Simply put, if physicians do not pay attention to ICD-10, reimbursement and collections will quickly grind to a halt come next October. Like trying to do a crossword puzzle without the "Up" clues, if physicians do not provide critical clinical information, the staff will not be able to select diagnosis codes.

"Without diagnosis codes, office encounter forms and surgical claims can't be closed or billed," reminds Zupko. "And that will lead to an immediate backflow of charges and payments."

Certainly, reimbursement is based on current procedural terminology (CPT) codes, "but it's the diagnosis code that supports the medical necessity," exclaims Margaret Maley, BSN, MS, and consultant with KarenZupko & Associates Inc, "and without it, you won't be paid at all."

In order to choose a diagnosis code, ICD-10 will require physicians to be more specific in their documentation, and provide details that they probably have not in the past, at least not consistently. This level of detail is particularly relevant for orthopedics, a specialty that has more ICD-10 codes than most others, fractures having the largest number of codes.

"Choosing a diagnosis code for fractures will be based on a specific classification system and that is a radical change," says Maley. "The correct ICD-10 code will require that open fractures of long bones are reported with the Gustilo classification, while physeal fractures must be documented with the specific Salter-Harris classification. The ICD-10 codes linked to proximal humerus fractures use a modified Neer Classification, and you'll need to document the correct zone to document sacral fractures."

These are perfect examples of why physicians must be involved in the conversion to ICD-10. No matter how bright they are, the billing company or the billing department cannot read physician minds. Staff can only select the right code if it is included in their documentation—and the electronic medical records (EMR) will not magically select the codes either. "So if you cringe at the thought of staff constantly chasing you down for more information, start learning now about how ICD-10 will require you to dictate office visits and operative reports differently than you have in the past," Zupko suggests.

Prepare for a Productivity Dip

If you survived the implementation of an electronic health record (EHR) or practice management system, you are already familiar with the confusion and slowdowns that take place shortly after go-live. "Plan for a decrease in physician and staff productivity," Maley says.

Physician productivity will primarily be hampered by the sheer number of codes orthopedists have in ICD-10. "The days of listing diagnoses codes on the super bill or maintaining a cheat-sheet that fits in your coat pocket are gone," according to Maley. "Laterality, new combination codes, and additional specifics have made the number of codes used by

Ms. Toth is Consultant, KarenZupko & Associates, Chicago, Illinois.

Address correspondence to: Cheryl L. Toth, Karen Zupko & Associates, 625 N Michigan Ave, Suite 2225, Chicago, IL 60611 (tel, 312-642-5616; fax, 312-642-5571; e-mail, ctoth@karenzupko.com).

Author's Disclosure Statement: The author reports no actual or potential conflict of interest in relation to this article.

Am J Orthop. 2013;42(12):544-546.

orthopedic surgeons explode. For example, there are 100 codes to describe osteoarthritis in ICD-10, more than twice the number used in ICD-9."

In addition, you can not close an encounter in an EHR without a diagnosis code. "If physicians currently choose diagnoses as they document office encounters, the practice will need to rethink the process of how office visits are documented, coded, and closed," Maley advises.

Staff too will experience a slowdown in efficiency and output. ICD-10 pilot results presented at the Medical Group Management Association (MGMA) 2013 annual conference indicated a decline of 50% in productivity when staff attempted to identify the proper ICD-10 codes from physician documentation. In the pilot study, coders extracted diagnosis codes for an average of 2 medical records per hour under ICD-10, compared with 4 or more records under ICD-9.[1] Analysis of Canada's ICD-10 implementation showed this same 50% decline in overall productivity.[2]

These declines will be temporary, but it does not mean you should not plan for them. "If today it takes a coder 10 minutes to review documentation and extract diagnosis codes, figure it might take that same person 17 minutes in ICD-10," Zupko warns. "Seven minutes may not seem like much, but if you see 35-40 patients per week, that's an extra 4 to 4.5 hours spent looking up codes."

One way to mitigate the productivity dip is by hiring additional coding staff now. "Don't wait until next summer, when qualified coders have all been snapped up by other groups or the hospital," advises Zupko. "Many coders will need additional anatomy and terminology training, because ICD-10 requires a higher level of knowledge in this area than ICD-9. Factor that into the hiring timeline as well," Maley adds.

"Pretty Good" Collections Are No Longer Good Enough

"If you think your billing and collections are 'pretty good,' they won't be good enough for ICD-10," says Zupko. "Predictions are that even prepared practices will see delays and denials."

An advisory report from the Health Information Management Services Society (HIMSS) estimates the potential for a 100%-200% increase in denial rates, and a 20%-40% increase in days in receivable[3]—a revenue cycle metric that measures how long it takes for a claim to be paid.

That means you need an all-hands-on-deck attitude toward cleaning up the Accounts Receivable in the early part of the year, and fine-tuning reimbursement and collection systems so that come October, the business office is running like a well-oiled machine. Being brilliant on the basics will keep cash flowing in the areas the practice has control over, which will help balance unavoidable payment delays and payor computer glitches.

Zupko suggests a multi-faceted approach. "Review receivables reports, and identify patient accounts and large overdue insurance balances that need to be resolved. Take a look at point of service collection processes in the office. Are staff missing copay collection opportunities? Would they benefit from additional training?"

Look also at the surgery scheduling process. "If you don't currently collect scheduling deposits or establish payment plans prior to surgery, it's time to consider it," Zupko advises.

10 Action Steps to Take Now

Dragging your feet on ICD-10 planning will not delay the deadline. Get organized, get focused, and complete these 10 actions by April 1, 2014.

1 Buy the book.

The paperback ICD-10 book provides the easiest way for practices to understand the architecture of the new system. Maley suggests purchasing it before the software. "Spend time evaluating the musculoskeletal and injury chapters," she suggests. "Once you look through the pages, it will be clear where the ICD-10 cross walking software can help, and where it will fall short."

For example, perusing the osteoarthritis you will understand why the cross walk comes up as unspecified because there was no single code for bilateral or posttraumatic osteoarthritis of the hip in ICD-9. You will also notice that some common codes have moved. Gout, for instance, is now located in Chapter 13 with the musculoskeletal diseases.

2 Collect and document plans from your software vendors, clearinghouses, top payors, and Worker's Compensation carriers.

What are the payor and carrier guidelines for coding medical necessity in ICD-10? How soon can you send test claims? Are all payors on schedule with their updated 1500 claim form implementation? Put the responses in a document that is organized and accessible to everyone. And task someone with monthly research and updates. "Many technology vendors are already providing resources, tools, and Webinars," says Zupko. "Some clearinghouses have even told us they are ready to accept test claims if practices want to send them. Take advantage of this support, much of which is free."

Table. **ICD-9 Frequency Report for Dr. A, With Charges and Payments**

ICD-9 Code	Description	Dr. A Frequency	Total Charges	Insurance Payments	Patient Payments	Total Payments
715.16	Osteoarthritis Knee DJD	1,059	$465,292	$149,858	$22,201	$172,059
726.10	Tendinitis/Bursitis Shoulder	370	$94,311	$32,864	$7,383	$40,248
836.0	Tear of Medial Cartilage or Meniscus of Knee, Current.	360	$53,831	$18,899	$8,740	$27,639

3 **Generate an ICD-9 frequency report for each physician and provider.**

This is a standard report in most practice management systems. Generate it for each physician or provider, for the last 12 months (**Table**).

"Not all diagnosis codes are created equal," Zupko says. "Some generate more revenue than others. This report allows you to focus on the top 25 diagnosis codes, and prioritize your documentation training." A few practice management systems, as well as many clearinghouses, can also associate charges and payments with the frequency data. Call your vendor or clearinghouse to find out your options.

4 **Cross-check the most-used ICD-9 codes in ICD-10.**

Ask billing staff to list all the ICD-9 codes, and then look up the new more detailed codes that are needed in ICD-10. The ICD-10 book contains this information, but the American Academy of Orthopaedic Surgeon's (AAOS) is a great way to speed this process. "The ICD-10 codes are loaded into Code-X 2013," Maley says, "which is a great educational tool for physicians to improve their documentation for ICD-10."

The Orthopaedic Code-X software allows surgeons and their business office to navigate critical coding databases, including CPT, ICD-9 and ICD-10 codes, and Global Service Data guidelines. For example, Code-X includes pick lists for fractures, and provides step-by-step guidance for the key documentation elements required for ICD-10. The 2014 update will have pick lists for arthritis as well. "Code-X gives you an easy way to keep your fingers in both ICD-10 and ICD-9," Maley adds, "since both databases are available at a click of a button."

Other effective ICD-10 "translation" software tools are also available. But avoid free, online General Equivalence Mappings (GEMs) translators, which often lead you to nonspecific, inaccurate codes that lack laterality.

5 **Pull 5 to 10 operative reports for each physician's top 5 procedures and conduct a 'gap analysis.'**

Analyze whether the reports include essential ICD-10 elements and pay particular attention to laterality and sequela, which are both critical elements in ICD-10. Ask the staff to list all the elements that were missing, but that are needed for them to find the ICD-10 codes. "These are the clinical details that physicians will need to dictate in order to support the selection of the new diagnosis codes," says Maley. "What staff identify as missing elements form the foundation of physician documentation education, flashcards, and other training materials."

Budget 2 to 3 weeks for staff to complete and deliver the analysis. "More if you have a general orthopedic practice," says Maley. "The more general the practice, the more codes you'll need to learn." After you completed the analysis for the top 5 procedures, continue with the rest. "The goal is to complete the entire gap analysis by end of March or beginning of April," suggests Zupko.

6 **Schedule training.**

Once the practice has a handle on where the gaps are, and which elements are missing from current dictation and documentation, physician training is the logical next step. Orthopedic-specific ICD-10 training is the most efficient use of the surgeons' time. The AAOS will hold workshops beginning in January.

7 **Modify your dictation and/or documentation templates.**

Use the results of the documentation gap analysis and the crossed ICD-10 codes lists. Assign a physician or mid-level provider the task of leading this effort. Set a goal to address 5 procedures per month.

8 **Run tests with your practice management system and clearinghouse vendors.**

This is a critical step to ensuring payment and cash flow so do it as early as you can; at least by the end of March. The worst thing you can do is wait until August or September; at that late date, you will be scrambling to meet the October 1 deadline.

9 **Apply for a line of credit.**

The Healthcare Billing and Management Association suggests this as a mitigation strategy against payment delays.[4] "The best time to obtain a line of credit is before you need it," Zupko says. "We advise practices to secure one in the first quarter of 2014." You might also consider holding off on end-of-the-year physician bonuses, and reserving these monies for cash flow uncertainties and training costs in 2014, just in case.

10 **Lay out critical deadlines on a calendar that everyone has access to.**

A great way to stay on top of deadlines is to log them on a timeline, and review it regularly. Create a central Outlook calendar on your internal network and set appointments for critical deadlines—such as new claim form testing dates or internal goals for completing ICD-9 to ICD-10 cross walks for high priority codes. "This is what Outlook alarms and reminders were made for," quips Zupko, who also suggests maintaining a large, wall calendar in the kitchen or break room. "Keeping deadlines front and center where everyone can see them helps maintain momentum."

References

1. McCann E. The ICD-10 Pilot That Was Just Plain 'Scary'. Government HealthIT. http://www.govhealthit.com/news/icd-10-pilot-was-just-plain-scary-coding-coders. Updated October 14, 2013.
2. Implementing ICD-10. A Canadian Perspective from the Front Line. Healthcare Financial Management Association (HFMA). Published February, 2009.
3. ICD-10 Transformation: Five Critical Risk Mitigation Strategies, 2011, HIMSS G7 Advisory Report.
4. ICD-10: Six Months Later, and We Still Have Questions, Healthcare Billing and Management Association. http://www.hbma.org/news/public-news/n_icd-10-six-months-later-and-we-still-have-questions. Published January 22, 2013.