ICD-10 FACTS

What Are ICD Codes?
ICD stands for the International Classification of Diseases. These codes are endorsed by the World Health Organization (WHO) and are utilized by Health Information Management departments across the U.S. (and the world) to codify the diagnoses for all patients.

How Do We Use ICD Codes?
These codes are used in a number of different ways including calculating inpatient payment like Medicare Severity Diagnosis Related Groups (MS-DRGs), adjudicating coverage for all outpatient, professional and inpatient care, compiling statistics, and assessing quality.

What Does the Transition from ICD-9 to ICD-10 Entail?
On October 1, 2014, the Centers for Medicare and Medicaid Services (CMS) has mandated that the U.S. transition from ICD-9 to ICD-10. There will be significant changes to the structure of codes (three to five numeric to three to seven alphanumeric), coding rules, terminology, and the sheer number of codes in use.

What is the Difference Between ICD-9 and ICD-10?
- Code structure is 3 to 5 numeric characters
- Code data (despite known limitations) is the basis for patient care improvement, quality reviews, medical research, and reimbursement

ICD-9
- Code structure is 3 to 7 alphanumeric characters
- Specific diagnosis and treatment information
- Code data (despite known limitations) is the basis for patient care improvement, quality reviews, medical research, and reimbursement
- Precise codes to differentiate body parts, surgical approaches, and devices used

ICD-10
- Code structure is 3 to 7 alphanumeric characters
- Specific diagnosis and treatment information
- Code structure is 3 to 7 alphanumeric characters
- Specific diagnosis and treatment information

MORE CODES, GREATER COMPLEXITY

NUMBER OF CODES

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnoses (DM)</td>
<td>~14 K</td>
</tr>
<tr>
<td>Procedure (PCS)</td>
<td>~72 K</td>
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</tbody>
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Examples of Diagnosis Code
- ICD-9 CM
  - Pressure Ulcer Codes
    - ~9 location codes (707.00 – 707.09)
    - Show broad location, but not depth (stage)
- ICD-10 CM
  - Pressure Ulcer Codes
    - ~125 codes
    - Show more specific location as well as depth, including L89.131 – Pressure ulcer of right lower back, stage I

Who Does This Impact?
- Outpatient, inpatient, and professional claims are impacted by ICD-10 CM (Diagnosis)
- Inpatient claims are impacted by ICD-10 PCS (Procedure)
- Current Procedural Terminology (CPT) does not change; used for all ambulatory and physician procedure reporting

Patient Access and Accounting
Preparing for All Potential Revenue Cycle Outcomes

What happened to our Discharge Not Final Billed (DFNB) and our Accounts Receivable (A/R)?
The worst case scenario of not preparing adequately for the transition (i.e., not updating IT systems, training coders, etc.) is that we would not be able to bill any discharge or date of service on or after October 1st, 2014. However, we are committed to ensuring that is not the case, but that doesn’t mean we won’t be faced with many challenges in our revenue cycle such as:

Revenue Risk
- Increased underpayments
- Increase in denials (both medical necessity and authorizations)
- Reduced point of service collections

Cash Flow Risk
- Increased DFNB
- Reduced clean claims rate as a result of failed claim checks
- Increased accounts receivable

Operational Risk
- More billing rework to get claims out the door
- Increased rework for collectors and denials staff

Numerous challenges will be faced across the Patient Access and Patient Accounting continuum and must be addressed prior to October 1, 2014.

Scheduling
Obtaining appropriate ICD-10 codes at the time of scheduling will be critical as we can no longer rely on descriptions of diagnoses in order to then generate the code used for medical necessity and authorizations.

Medical Necessity
Checking for medical necessity (and ultimately preventing denials) is an essential part of the revenue cycle. With ICD-10 this becomes more complicated as we must now ensure the correct ICD-10 diagnosis code and CPT match. It is essential we receive the correct and complete codes at time of scheduling.

Authorizations
Authorizations are frequently obtained through a combination of diagnosis codes (ICD) and procedure codes (CPT). With incorrect or missing codes, we will be at risk for not obtaining an authorization (and thus associated denials) or expending substantial resources to do so (and thus increasing our cost to collect).

Billing
As a result of difficulty in coding ICD-10 such as missing/incomplete documentation and query response delays, the billing process, and its impact on DFNB, could see significant delays.

Denials Management
An expected increase in technical and clinical denials could result from this transition as we learn to get medical necessity, authorizations, and code in the ICD-10 world.

Underpayments
Payers like hospitals are faced with this transition and must make a number of changes to their reimbursement structure. As a byproduct we expect payment delays or underpayments from key payers. This will require much closer scrutiny on our part to maximize our payments at a time of great financial strain.

Key Takeaway:
Patient Access and Patient Accounting are the areas most hard hit. After the transition on October 1, 2014 given all the uncertainties in documentation, IT, and coding. However, leading up to the transition, we have the opportunity to improve existing operations and processes to make the revenue cycle more efficient and improve our overall ability to get paid as cheaply, accurately, and quickly as possible. Taking these steps in advance will allow us to more smoothly handle the ICD-10 transition and maintain strong DFNB, A/R, and cash levels through the transition.