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# ICD-10: Capturing the Complexities of Health Care

This project is a collaborative effort  
by 3M Health Information Systems and the  
Healthcare Financial Management Association

Coding is the language of health care for both providers and payers. The transition to the ICD-10-CM (diagnoses) and ICD-10-PCS (procedures) coding system is expected to take place within the next few years. The new system provides a significant opportunity to improve the capture of information about the increasingly complex delivery of health care. The ICD-10-CM and PCS coding system will bring greater coding accuracy and flexibility to hospitals, health systems, and payers, presenting opportunities for detailed record-keeping and enhanced documentation to support accurate payment.

As medical advances continue, public reporting of quality indicators is expected to become more prevalent, with greater emphasis placed on payment for quality. Detailed and accurate information is essential for good reporting. Although the implementation of the new

coding system would not be before October 2007, hospitals, health systems, and payers need to begin preparations for the transition now. Hospitals and health systems should start by addressing the implications of the new system for cash flow, information technology, clinical systems, staffing, and vendor and payer relationships.

## The History of ICD-9 and ICD-10

The *International Classification of Diseases, Ninth Revision*, or ICD-9 for short, was developed by the World Health Organization (WHO) and was the ninth iteration of the International Classification of Diseases (ICD), which originated in the late 19th century as the International List of Causes of Death. Originally designed to standardize the international reporting of causes of death, ICD took on a life of its own as the



basis for illness and treatment classification in most of the world's industrialized nations. In the United States, a modified version is used, *The International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM). It includes a classification for procedures performed in hospitals.

In the United States, ICD-9-CM is the basis for not only disease and illness classification, but also for payment justification. It has become embedded in our reimbursement system as a core classification system used by hospitals and outpatient care entities to code claims for public and private health insurance reimbursement. The ICD system is also used for classification of morbidity data, indexing of patient records, patient care review, basic health statistics, and research.

As a result of international interest in classification system improvement, WHO developed ICD-10 as a replacement for ICD-9. ICD-10 is already in use in many of the industrialized countries in its original form. Canada and Australia adopted ICD-10 after making clinical modifications tailored to their specific needs. In this country, the WHO version of ICD-10 was implemented for the coding of death certificates in January 1999. ICD-10-CM and ICD-10-PCS (the new

Procedure Coding System developed for HHS to replace the procedure volume of ICD-9-CM) are slated to be implemented as the new standard for all inpatient coding.

Over the years, the ICD-9 system has outgrown its intended level of specificity and affects the ability to compare data precisely for clinical, research, and payment purposes. The current system has limitations that make it difficult to capture diagnoses and procedures made possible by recent advances in medicine and technology. These limitations can have negative implications for accurate reimbursement.

## Support for the Transition

National healthcare organizations, including the American Hospital Association, the Federation of American Hospitals, and the American Health Information Management Association (AHIMA), have supported the transition from ICD-9-CM to ICD-10-CM and PCS. According to Linda Kloss, MA, RHIA, vice president and CEO of AHIMA, "The uses being made of coded data today go well beyond the purposes for which the system was designed or even contemplated in the 1970s." Kloss said that codes

### **The Move to ICD-10 in Canada and Australia**

The Canadian and Australian healthcare systems reported some initial declines in productivity at the outset of their ICD-10 implementations. However, in general, productivity for these healthcare systems improved within a few months and the coding process became easier. It's important to keep in mind that these nations have single-payer systems, not a complex, mixed public/private payment system like that of the United States.

## ICD-9-CM, ICD-10-CM / ICD-10-PCS Comparisons

	ICD-9-CM	ICD-10-CM	ICD-10-PCS
<b>Diagnosis Usage</b>	Inpatient and Outpatient	Inpatient and Outpatient	
Number of Characters	3-5 Alphanumeric	3-7 Alphanumeric	
Number of Codes	13,000	120,000	
<b>Procedure Usage</b>	Inpatient *		Inpatient †
Number of Characters	3-4 Numeric		7 Alphanumeric
Number of Codes	4,000		200,000

\* Some hospitals currently dual code outpatients with ICD-9-CM procedure codes for internal management purposes.

† Some hospitals may, in the future, choose to dual code outpatients with ICD-10-PCS for internal management purposes.

have a number of important uses in today's healthcare environment, including the following:

- Measuring the quality, safety, and efficacy of care
- Designing payment systems and processing claims for reimbursement
- Conducting research, epidemiological studies, and clinical trials
- Setting health policy
- Designing healthcare delivery systems
- Monitoring resource utilization
- Identifying fraudulent practices
- Managing care and disease processes
- Tracking public health and risks
- Providing data to consumers regarding costs and outcomes of treatment options<sup>1</sup>

In contrast to the ICD-9-CM system, which uses three- to five-digit codes, ICD-10-PCS is based on a seven-character alphanumeric code that uses the digits 0-9 and the letters A-H, J-N, and P-Z. This system is able to provide a far greater level of specificity than ICD-9 and is more conducive to expansion. The resulting completeness and accuracy of the codes used allows statistical information to be kept at a very detailed and thorough level. A recent study conducted by the Rand Corporation (commissioned by the National Committee on Vital and Health Statistics) presented both the benefits and expenses of adoption of ICD-10.

Benefits are grouped into five major categories:

- More accurate payment for new procedures
- Fewer miscoded, rejected, and improper reimbursement claims
- Better understanding of the value of new procedures
- Improved disease management
- Better understanding of healthcare outcomes (not fully evaluated)

Costs are classified in three major categories:

- Costs of training
- Productivity costs
- System changes

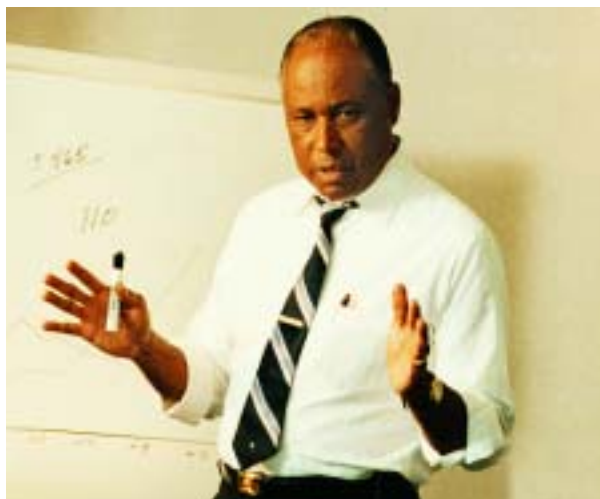


<sup>1</sup> Kloss, Linda, AHIMA's Statement Regarding Replacement of ICD-9-CM Procedural Coding System, statement delivered to HCFA, ICD-9 Coordination and Maintenance Committee, Thursday, May 17, 2001, [www.cms.hhs.gov/paymentsystems/icd9/icd051701.pdf](http://www.cms.hhs.gov/paymentsystems/icd9/icd051701.pdf).

The report notes that, more likely than not, switching to ICD-10-CM and PCS has the potential to generate more benefits than costs.<sup>2</sup> Accurate information generated by ICD-10-CM and PCS can provide key metrics for monitoring some of the most important and pressing healthcare issues in the United States—issues related to cost, quality, and access to care.

For providers, ICD-10-CM and PCS will bring more precise documentation of clinical care and potentially more accurately determined reimbursement for hospitals. With its potential for improved coding accuracy and efficiency, ICD-10-PCS is intended to help hospitals justify accurate reimbursement for a range of procedures.

The U.S. healthcare system faces quality concerns attributed to medical errors, fragmented care, and inadequate systems, further compounding the cost and quality balance. In addition to its payment implications, the new system represents notable opportunities for hospitals and health systems to code more accurately and contribute to healthcare quality improvement initiatives. The more refined record-keeping and quality measurement the new system will allow will also drive public reporting of quality improvement metrics.



Research demonstrates that access to good health care is empirically associated with better care outcomes. Unfortunately, within the United States, nearly 43 million Americans are uninsured, while outside the United States, countries with universal healthcare coverage are challenged to provide their populations with equitable and efficient access to care. An improved data set of detailed information can serve to facilitate access to care.

## Transition Process

The transition will create challenges for the U.S. health system. When Canada and Australia made their transitions to their respective clinical modification and procedure coding systems, the key critical success factors were early planning, leadership support, and careful project management. Providers should begin now to prepare for the implications of the transition for patient financial services, information technology, clinical areas, health information, and staff training.

Healthcare providers should first establish an interdisciplinary steering committee to oversee the transition. Such a committee can provide oversight and direction to the various entities of the organization. Clearly, finance, health information management (HIM), and information systems staff need to be involved at this level and at the task force or working group level.

Then, providers should create task forces to prepare for and execute the transition. Others who should be involved at the appropriate time include representatives of the medical staff, nursing, clinical departments, quality assurance, risk management, case management, the legal department, managed care contracting, medical staff/physician relations, admitting/discharge, and patient and family services. It's important to acknowledge that a broad transitional effort to ICD-10 will not succeed without input and buy-in from every key stakeholder group in the organization.

## Implementation Issues

### Patient Financial Services and Health Information Management

In the billing and patient financial services area, the transition to ICD-10-CM may lead to coding delays that can affect the hospital's cash flow and days in accounts receivable. Hospitals can mitigate these delays and their resulting problems by adopting the following measures:

*Early planning.* Leaders of PFS and HIM departments should begin working as early as possible to anticipate, plan for, and avert problems relating to slower coding. Such planning should be a top priority for the organization, as HIM will be the area in which initial slowdowns will occur. Those slowdowns and the resulting loss of productivity (and therefore reimbursement and charge capture) can have a domino effect across the organization.

The organization should work proactively to measure and analyze potential slowdowns in productivity and throughput. To prepare for anticipated slowdowns and implementation issues, hospitals may want to add staff (temporary or otherwise) as necessary and perform “dry runs” of the coding process.

*Training for coders, PFS staff, and physicians.* Coders should be trained regarding their specific role in the new ICD-10 system as soon as is practically possible. The ICD-10-PCS requires a higher level of expertise in anatomy and physiology than does the ICD-9. In fact, some coders currently working in hospitals may find this requirement particularly challenging. It is one reason hospitals should perform a comprehensive gap analysis, which in this context should include an analysis of the education levels, skills, and readiness of coders to adapt to a system change.



### Steps for the Transition

The following are essential aspects of preparation for the transition to ICD-10 for hospitals and health systems.

- Development of mechanisms for controlling the documentation of care/treatment for clinical and financial purposes
- Creation of a contextual “map” of all software interfaces, databases, and forms
- Analysis and action in regard to contract renewals for software programs
- Establishment of task forces and working groups from the various disciplines and divisions of the organization
- Education and training of all users
- Financial planning for the impact of the shift
- Evaluation of policies and procedures



### Keeping the “Old” Data

Given the pervasiveness of coded data and its important role in multiple functions within the organization, there is no question that many hospital departments will be affected by the transition to ICD-10. The implications of the transition for the utilization review, quality assurance, risk management, and case management areas should be examined.

One of the questions that hospitals will have to sort out is, what should be done with old data? Most hospitals will find it a cumbersome yet necessary task to keep old ICD-9 data alongside newer ICD-10 data. Even more challenging is the need to be able to use the two types of data seamlessly for a variety of clinical and other uses, such as outcomes measurement and quality reporting.

Hospitals will find it helpful to have a working group that will help steer a course forward in these non-billing areas and will work with those leading the transition in coding and billing processes to make sure that the strategic, practical, and technological needs of all areas are considered.

This analysis of coders’ skills will give the organization enough time to help individuals get up to speed, literally, and gain the education and knowledge needed to transition to ICD-10.

Healthcare organizations may want to provide in-house courses or require their coders to pass some sort of in-house certification before they take on ICD-10 coding full-time. Without these requirements, healthcare providers may find it difficult to determine skill levels of coders, particularly because it is not yet known whether coders who have the current credential of Certified Coding Specialist will be tested on ICD-10 knowledge. Indeed, the issue of credentialing is a delicate one that still requires some evaluation. In addition to understanding the person-hours and education that the transition will require, it will be important to know the funding implications of those requirements.

The same concept applies to the PFS side. PFS staff should be trained to understand the technical and procedural changes that will take place, and procedures and processes should be established to help facilitate PFS-HIM communication, as that communication channel will be tested more than any other in the organization.

Hospitals also should invest in training for medical staff to make them aware of the transition to ICD-10. Though physicians may engage in some self-directed training through courses offered by physician organizations, they also will need training in how to interact optimally with the HIM department regarding documentation matters.

#### *Review of the hospital’s billing and coding policies.*

Both broad policy issues and practical aspects of these policies and procedures should be carefully considered. The task force representing key stakeholder groups should contribute to this process.

## Software and Vendors

The changes required of software vendors to support the transition to the ICD-10 system may present additional challenges.

Vendors with software applicable to coding, billing, and claims will need to offer new software programs or significantly modify their current billing software to support the ICD-10 system. Among the systems that certainly will be affected are the following: reports, clinical decision support, HIM functions, physician orders, billing, quality assurance, utilization review, and registration/preadmission.

Hospital leaders should take the following steps to address vendor and software issues relating to the transition to the new coding system:

- Determine as early as possible what steps will need to be taken with vendors and how to facilitate a rapid transition on the vendor and software side.
- Perform a gap analysis and action plan that will ensure the organization does not fall behind in bridging the requirements of software, information technology, and vendors.
- Map out the organization's entire information system, paying particular attention to those areas that relate to coding, billing, and claims (which inevitably means most points of the system).
- Investigate and prepare for the distinct possibility that dual systems or mapped systems will need to be in place for a number of areas for a period of time.
- Plan for possible need to add new IS staff during the transition.
- Work with vendors to ensure that interfaces in the above-mentioned areas allow codes to pass through so that billing can be accomplished. Careful attention to these interfaces will streamline the switch to ICD-10.
- Bear in mind the vendor's ability to ensure a smooth transition to ICD-10 when considering contract renewals.

## A Challenge and an Opportunity

In the end, hospital-based organizations are faced with many choices, strategic and practical, in preparing for the transition to ICD-10. Hospital leaders should neither put off preparing for the transition nor shrug off this mandate as yet another federal government annoyance.

Care delivery ultimately will change in multiple ways because of the introduction of ICD-10. There is real potential for improvement in care management, given the greater level of detail inherent in the ICD-10 system. Initially, the challenges may be more apparent than the opportunities. But hospital organizations whose leaders plan carefully and strategically while accepting the reality of this mandated change have the best chances of moving forward to embrace the opportunity inherent in the ICD-10 transition, as well as to avert the problems inherent in its pitfalls.

The coding changes driven by the shift to ICD-10 will touch most aspects of hospital operations and patient care, so the shift is not to be taken lightly. On the other hand, with careful and clear-eyed planning, hospitals can come through this transition in a very good position to manage the reimbursement and regulatory challenges of the next decade. Clearly, the smartest leaders in the smartest hospitals will put their organizations on firm footing to meet the future with success.





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