Frequently Asked Questions about ICD-10-CM/PCS

Q: **What is ICD-10-CM/PCS?**

A: ICD-10-CM (International Classification of Diseases -10th Version-Clinical Modification) is designed for classifying and reporting diseases in all healthcare settings.

ICD-10-PCS (Procedure Classification System) replaces the ICD-9-CM procedure coding system, and will only be required for hospital reporting of inpatient services.

The development of ICD-10-CM and ICD-10-PCS involved extensive input from the healthcare industry, including the physician community. Much of the additional clinical detail was recommended by physician groups.

When speaking of both these new classifications, the term "ICD-10" is often used.

Q: **Who has to comply with ICD-10?**

A: All HIPAA-covered entities must convert to ICD-10-CM for reporting diagnoses and ICD-10-PCS for facility reporting of inpatient services, from the 36 year old ICD-9-CM version.

Q: **Why does the U.S. need to replace ICD-9-CM?**

A: Developed in the 1970s, the ICD-9-CM code set no longer fits with the needs of the 21st century healthcare system. ICD-9-CM is used for many more purposes today than when it was originally developed and is no longer able to support current health information needs.

Q: **Why is it important not to further delay the implementation of ICD-10?**

A: Any ICD-10 delay is disruptive and costly for healthcare delivery innovation, payment reform, public health, and healthcare spending. Considerable time and resources have been invested in financing, training, and implementing the necessary changes to workflow and clinical documentation. Each delay adds substantially to the cost of ICD-10 conversion – a one year delay is estimated to have cost the health care sector as much as $6.8 billion dollars. These costs include:

- ICD-9-CM versions of systems will have to be updated to remain current and usable.

- Each delay requires ICD-10 conversion work already performed to be updated, retested, and reintegrated – greatly increasing the cost of conversion.

- Maintaining coders' ICD-10 coding skills through either additional education or ongoing ICD-10 coding practice.

- Costs associated with the inability to effectively use healthcare date to improve quality of care, patient safety, and patient outcomes because the quality of healthcare data is progressively deteriorating as long as the US continues to rely on the outdated and imprecise code set.

In addition to the direct costs of the delay, significant ongoing costs are being incurred by the failure to replace the ICD-9 code set. Continued use of the out-of-date and imprecise ICD-9-CM code set results in costs associated with:

- Inaccurate decisions or conclusions based on faulty or imprecise data
- Administrative inefficiencies due to reliance on manual processes
- Coding errors related to code ambiguity and outdated terminology

Q: Will the use of CPT codes be affected?
A: No. ICD-10 procedure codes will only be used for facility reporting of hospital inpatient services. Current Procedural Terminology (CPT®) codes will continue to be used for physician and outpatient services.

Q: Do physicians need to use all the codes in ICD-10?
A: Just as no healthcare provider uses every code in ICD-9-CM today, physicians and other providers will not use all the codes in ICD-10-CM. They will use a subset of codes based on their practice and patient population. The ICD-10-CM code set is like a dictionary that has thousands of words, but individuals use some words very commonly while other words are never used. Also, laterality accounts for nearly half of the increase in the number of codes in ICD-10-CM.

The development of ICD-10-CM was based extensively on public clinical input, with much of the additional specificity being requested by physician groups.

Q: Is reporting of external cause codes required?
A: Just as with ICD-9-CM, there is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of external cause codes in ICD-10-CM is not required.

Q: Will the use of unspecified codes be allowed after ICD-10 is implemented?
A: Yes, as unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient's condition at the time of that particular encounter.

Q: Why shouldn't the US healthcare industry wait for ICD-11 instead of transitioning to ICD-10?

A: Waiting until ICD-11 is ready for implementation in the US is not a viable option, as waiting that long to replace the ICD-9-CM code set would seriously jeopardize the country's ability to evaluate quality and control healthcare costs. US healthcare data is being allowed to deteriorate while the demand increases for high-quality data that can support new healthcare initiatives. Based on the World Health Organization's current timeline, ICD-11 is expected to be finalized and released in 2017. For the US, that date is the beginning, not the end, of the process toward adoption of ICD-11.

The process of evaluating ICD-11 for use in the US, developing a national modification to meet US information needs, and developing a procedure coding system would take at least a decade, followed by the rulemaking process to adopt ICD-11 as a HIPAA code set standard. In the case of ICD-10, it took eight years to develop a US modification of ICD-10 and a procedure coding system, and 19 years for a final rule to be published.

Also, implementing ICD-10-CM/PCS is an important step on the pathway to ICD-11.

Q: How costly is the ICD-10 transition for small physician practices?

A: Recent surveys have shown the cost of the transition for small physician practices to be much lower than previously suggested. For example, a survey conducted by the Professional Association of Health Care Office Management (PAHCOM) found that the average ICD-10-related expenditures for a physician practice with six or fewer providers is $8,167 with average expenditures per provider of $3,430. Another study estimated the ICD-10 conversion costs for an office with three providers to be $1,960-$5,900.

One reason the transition costs have been shown to be less than earlier predictions is because many software vendors are providing ICD-10 system updates for no additional cost. Also, numerous free or low-cost educational and implementation resources and tools are available from CMS and professional organizations.

Q: How likely are significant payment disruptions for physician practices following the transition to ICD-10?

A: Not very likely, especially for physician practices that prepare for the transition. Testing has demonstrated that CMS systems are ready to accept and process ICD-10 claims. Also, physician payment is primarily driven by CPT codes, not ICD diagnosis codes. However, to mitigate any risk whatsoever, it is recommended that CMS grant "advance payments" to any physicians that do experience cash flow disruptions as a result of the ICD-10 transition. CMS already has existing payment policies that it uses when a provider has incurred a temporary delay in its billing process causing financial difficulties for a provider.

Q: **Is "dual coding" a feasible approach to address concerns about the potential financial impact of the ICD-10 transition on small physician practices?**

A: No, dual coding (acceptance of either ICD-9 or ICD-10 codes for dates of service after October 1, 2015) is not practical or feasible. A dual coding system is <u>not</u> a simple solution, but is fraught with difficulties that have the potential to undermine the data infrastructure of the healthcare industry. It will confuse claims processing and negatively impact the handling of important patient clinical information and may affect patient care. It would require extremely complex and costly changes to major payment, clearinghouse and provider systems. The communication of health information between providers would be compromised, adversely impacting the quality of patient care and increasing the potential for patient harm. CMS has stated that they and many commercial health plans are unable to process claims for both ICD-9 and ICD-10 codes submitted for the same dates of service, so a dual coding approach is not possible.

Approaches such as advance payments are more practical and effective than the widespread disruption that would be caused by a dual coding system.

Q: **What ICD-10 external testing opportunities are available?**

A: Both private and public payers have been conducting extensive testing with their trading partners. Medicare is conducting both acknowledgement testing (claim acceptance) and end-to-end testing (claim acceptance and adjudication). Providers, suppliers, billing companies, and clearinghouses are welcome to submit acknowledgement test claims to Medicare anytime up to the October 1, 2015, implementation date. In addition, CMS is highlighting this testing by offering four separate weeks of ICD-10 acknowledgement testing – two each in 2014 and 2015.

During 2015, CMS is planning to offer three separate end-to-end testing opportunities. The first of these was held in January, and CMS was able to accommodate all volunteers. CMS is also working with state Medicaid agencies to conduct end-to-end testing.

Q: **Have the results of Medicare external testing been successful?**

A: Yes, the testing results have been very successful. While acceptance rates for acknowledgement testing weeks ranged from 89% to 76%, negative test claims were included, meaning that errors were intentionally included in some claims to make sure the claim would be rejected).

For the first Medicare fee-for-service end-to-end testing week conducted in January, participants were able to successfully submit ICD-10 claims and have them processed through the Medicare billing systems.

- 56% of the test claims received were professional, and for these claims, no issues were identified and zero rejects were due to front-end CMS systems issues.
- Only 3% of rejected claims were related to ICD-10 – most rejections were due to errors unrelated to ICD-10.

Q: What is the value of ICD-10?

A: The improved clinical detail, better capture of medical technology, up-to-date terminology, and more flexible structure will result in:

- Higher quality information for measuring healthcare service quality, safety, and efficiency
- Improved ability to manage chronic diseases by better capturing patient populations
- More accurate reflection of patients' clinical complexity and severity of illness
- Improved ability to identify high-risk patients who require more intensive resources
- Improved information sharing, which can enhance treatment accuracy and improve care coordination
- Improved efficiencies and lower costs
- Greater coding accuracy and specificity
- Greater achievement of the benefits of electronic health records
- Recognition of advances in medicine and technology
- Improved ability to measure outcomes, efficacy, and costs of new medical technology
- Better support of medical necessity of services provided
- Fewer claims denials
- Global healthcare data comparability
- Improved ability to track and respond to public health threats
- Reduced need for manual review of health records to perform research and data mining and adjudicate reimbursement claims
- Reduced need for supporting documentations to support information reported on claims
- Reduced opportunities for fraud and improved fraud detection capabilities
- Development of expanded computer-assisted coding technologies that will facilitate more accurate and efficient coding and alleviate the coder shortage
- Space to accommodate future expansion