



What You Need to Know for the Upcoming Transition to ICD-10

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W H I T E P A P E R | J U N E 2 0 1 2



This white paper is for educational purposes only and does not necessarily reflect the AMA's position on ICD-10.

Currently, the US health care industry uses ICD-9-CM codes for identifying and reporting diagnoses and procedures. ICD-9-CM stands for International Classification of Diseases, Ninth Revision, Clinical Modification and is based on the World Health Organization's (WHO) ninth revision of the International Classification of Diseases. Although ICD-9-CM had been in widespread use in health care, the Health Insurance Portability and Accountability Act (HIPAA) named it as the standard code for reporting diagnoses and inpatient procedures as of 2003.

In 2009, the Department of Health and Human Services (HHS) published a regulation requiring the replacement of the ICD-9-CM code set with the updated version, ICD-10. The deadline for transition to ICD-10 has been extended several times. The initial deadline for transition to ICD-10 was set for October 1, 2013. This date was an extension of two years from the date first proposed by HHS, which the American Medical Association (AMA), along with over 100 physician state and specialty societies, expressed deep concerns over, considering the significant work required to complete such a transition. Many organizations have continued to voice concerns about the aggressive timeframe to implement such a complex code set. In early 2012, the AMA began advocating for the halt of implementation of ICD-10. In February 2012, HHS announced it would further delay the compliance date. As of April 2012, the new proposed compliance date is October 1, 2014.

What is ICD-10?

ICD-10 or the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS) are an improvement over the ICD-9 code set. The ICD-10 code sets provide for expanded detail for ambulatory and managed care, and injuries, along with combined diagnosis/symptom codes to better define certain conditions, increased specificity through greater code length, and ability to specify laterality.

With respect to ICD-9-CM:

- ICD-10-CM is the diagnosis code set and is the updated version of ICD-9-CM Volumes 1 and 2.
- ICD-10-PCS is the code set of inpatient procedure codes and is the updated version of ICD-9-CM Volume 3.



ICD-10-CM

Additional information on ICD-10-CM can be found on the NCHS Web site at www.cdc.gov/nchs/icd/icd10cm.htm.

ICD-10-PCS

More information on ICD-10-PCS is available at www.cms.hhs.gov/ICD10/01_Overview.asp#TopOfPage.

The regulation to implement ICD-10 names ICD-10-CM for reporting diagnoses in all clinical situations and ICD-10-PCS for inpatient procedures only. The Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) will continue to be the code sets for reporting ambulatory procedures.

The National Center for Health Statistics (NCHS) under the Centers for Disease Control and Prevention (CDC) is responsible for the development and maintenance of ICD-10-CM. The NCHS modifies the World Health Organization (WHO) version of the codes for use in the United States. Information on ICD-10-CM is available from the NCHS (www.cdc.gov/nchs/icd/icd10cm.htm).

The Centers for Medicare and Medicaid Services (CMS) is responsible for the development and maintenance of the inpatient code set ICD-10-PCS, which is unique to the United States. Information on ICD-10-PCS is available from CMS (www.cms.hhs.gov/ICD10/01_Overview.asp#TopOfPage).

Differences between ICD-9 and ICD-10

There are structural differences between ICD-9 and ICD-10 that will make converting to the updated code set complex. Table 1 provides a comparison of the features of the ICD-9 and ICD-10 diagnosis code sets.

Table 1 – Comparisons of the Diagnosis Code Sets	
ICD-9	ICD-10
3 to 5 characters in length	3 to 7 characters in length
Approximately 13,000 codes	Approximately 68,000 available codes
First character may be alpha (E or V) or numeric; characters 2–5 are numeric	Character 1 is alpha; characters 2 and 3 are numeric; characters 4–7 are alpha or numeric
Limited space for adding new codes	Flexible for adding new codes
Lacks detail	Very specific
Lacks laterality	Has laterality (i.e., codes identifying right vs. left)

The expanded number of characters of the ICD-10 diagnosis codes provides greater specificity to identify disease etiology, anatomic site, and severity.

ICD-10 Code Structure:

Characters 1 through 3 — Category

Characters 4 through 6 — Etiology, anatomic site, severity, or other clinical detail

Character 7 — Extension



The following example shows the more detailed information gained through the added characters.

- S52 Fracture of forearm
- S52.5 Fracture of lower end of radius
- S52.52 Torus fracture of lower end of radius
- S52.521 Torus fracture of lower end of right radius
- S52.521A Torus fracture of lower end of right radius, initial encounter for closed fracture

Table 2 is a comparison of the differences in the features between the ICD-9 and ICD-10 procedure code sets.

Table 2 – Comparisons of Procedure Codes	
ICD-9	ICD-10
3 to 4 numbers in length	7 alpha-numeric characters in length
Approximately 3,000 codes	Approximately 87,000 available codes
Based on outdated technology	Reflects current usage of medical terminology and devices
Limited space for adding new codes	Flexible for adding new codes
Lacks detail	Very specific
Lacks laterality	Has laterality
Generic terms for body parts	Detailed descriptions for body parts
Lacks descriptions of methodology and approach for procedures	Provides detailed descriptions of methodology and approach for procedures
Lacks precision to adequately define procedures	Precisely defines procedures with detail regarding body part, approach, any device used, and qualifying information

The additional characters in the ICD-10 procedure code set allow for identifying body system, root operation, body part, approach, and device involved in the procedure. For example, the code structure in the Medical and Surgical section is:

Character	1	2	3	4	5	6	7
Definition	Name of Section	Body System	Root Operation	Body Part	Approach	Device	Qualifier



The following example identifies the meaning of each character of the code.

Right knee joint replacement = 0SRD0JZ
0 = Medical and Surgical Section
S = Lower Joints
R = Replacement
D = Knee Joint, Right
0 = Open
J = Synthetic Substitute
Z = No Qualifier

Did You Know...

The letters I and O are not used in ICD-10 procedure codes so as to avoid confusion with the numbers 1 and 0, respectively.

Why Convert to ICD-10 Now?

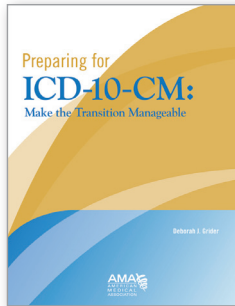
Many believe that the ICD-9 code sets have become outdated and are no longer workable for treatment, reporting, and today's payment processes. ICD-9 has been used widely in the United States since 1978. The WHO endorsed ICD-10 in 1990 and many countries have adopted modified versions of it.

The age of the ICD-9 code sets means that it does not accurately reflect advances in medical technology and knowledge. The ICD-9 diagnosis codes are divided into chapters based on body systems. During the years of maintaining and expanding the codes within chapters, the more complex body systems ran out of codes. The lack of codes within the proper chapter resulted in new codes being assigned in chapters of other body systems. For example, new cardiac disease codes may be assigned to the chapter for diseases of the eye. The rearranging of codes makes finding the correct code complicated.

Another driver for replacing ICD-9 is the increased specificity of ICD-10. The belief is that more specific data will improve identification of diagnostic trends, public health needs, epidemic outbreaks, and bioterrorism events. The more precise codes are supported by some as providing potential benefits through fewer rejected claims, improved benchmarking data, improved quality and care management, and improved public health reporting.

What the Compliance Date Means

According to the existing regulation, all services and discharges on or after October 1, 2013, will be required to use the ICD-10 codes. The ICD-10 codes cannot be submitted in transactions or used in any other reporting prior to the compliance date. After the compliance date, ICD-9 codes will not be accepted and any transactions with ICD-9 codes will be rejected. There is no guarantee that this deadline will be postponed to October 1, 2014.



More specific details on project planning are available in the AMA publication *Preparing for ICD-10-CM: Make the Transition Manageable*.

How to Begin Preparing Now for ICD-10

Practices need to develop and carry out a project plan to implement ICD-10. The project plan should include creating an inventory of your current systems and processes that use ICD-9, establishing a budget for the conversion, coordinating with your vendors, payers, billing service and/or clearinghouses, identifying work flow changes, training staff, and testing revised processes with your vendors and payers. More specific details on project planning are available in the AMA publication *Preparing for ICD-10-CM: Make the Transition Manageable*.

The first step is to conduct a practice assessment. The goal for a practice assessment is to capture a high-level understanding of how and where ICD-9 diagnosis codes are currently used in the practice. All of these current uses of ICD-9 codes will need to be updated to ICD-10. During the practice assessment, ask the following questions:

- Where do we use diagnosis codes?
- What processes are involved in these activities? Is it done via a HIPAA electronic transaction, phone, paper, web portal, etc.?
- What computer systems (e.g., practice management system, electronic health record) and software programs are used in these activities?
- Who are the people that work with the codes?

A simple approach to the practice assessment is to follow a patient through the office from the time they make an appointment until the visit is billed. As you complete the assessment, make a list of the activities that use diagnosis codes, the specific processes used to complete that activity, any computer systems or software programs that are used, and the staff who complete the work. This will become your inventory of everything that will need to be updated for ICD-10.

Pre-visit

Consider the following questions about a patient scheduling an appointment:

- Do you check eligibility?
- Do you need a referral?
- Do you need prior authorization?
- Do you use a patient problem list?
- Do you maintain a disease registry?



Visit

Consider the following questions about a patient being seen by a clinician:

- Do you use an encounter form or superbill?
- How do you document the encounter?
- Do you write orders?
- Do you write referrals?

Post-visit

Consider the following questions about other clinically-related activities completed after the patient's visit:

- Do you create consultation reports?
- How do you update patient problem lists?
- How do you update the disease registry?
- Do you do public health reporting?
- Do you do quality reporting?
- Do you do research?

Billing

Consider the following questions about billing for the patient's visit:

- How do you determine the diagnosis code?
- Do you use any coding tools?
- Are there other billing-related activities that use diagnosis codes?
- Do you perform chart audits?

After completing the practice assessment, you will have a better idea of the scope of the work needed to implement ICD-10. You can use the information gathered in the assessment to identify the remainder of the work for your project plan.

Crosswalking between ICD-9 and ICD-10

Many health care providers may believe that they can simply crosswalk or map an ICD-9 code to an ICD-10 code as a substitute to fully learning and implementing ICD-10. Be cautious, however, about attempting to use only a crosswalking method to obtain ICD-10 codes. Because of changes in concepts between ICD-9 and ICD-10, diagnosis information within a code can be gained or lost when crosswalking.



NCHS, the developer of the ICD-10 diagnosis code set, has developed the General Equivalency Mappings (GEMs), which map ICD-9 to ICD-10 and vice versa. The GEMs are considered to be the authoritative source for crosswalking between ICD-9 and ICD-10 and they are available for free to the public. The GEMs “attempt to find corresponding...codes between the two code sets, insofar as this is possible,” according to the GEMs Documentation and User’s Guide, 2009 version. The GEMs do not provide an exact crosswalk between the codes. An exact one-to-one matching of the ICD-9 and ICD-10 codes cannot be made due to changes in structure and concepts between ICD-10 and ICD-9.

Conclusion

The implementation of ICD-10 will be complex and will impact most areas of a practice. While there is a proposal to delay the compliance date until October 1, 2014, this does not mean that your conversion can wait. Practices need to begin working now to assess where they use diagnosis codes, how they use them, and who uses them so they are prepared to make necessary process and system changes and provide training to those who will need it. Completing this work will support a smooth transition to ICD-10 in time for the compliance deadline.

Visit ama-assn.org/go/icd10
for a comprehensive list of ICD-10 resources
published and sold by the AMA.

Free resources may be accessed at
ama-assn.org/go/ICD-10.

To enroll in a one-day workshop
on ICD-10-CM coding, visit
ama-assn.org/go/icd10workshops.