Road Map to ICD-10-CM
Analyze ICD-10's Impact on Your Practice

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Get an in-depth look at the systems and processes impacted most.

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The goal of an impact analysis is twofold. The first objective is to gather relevant information from each department to obtain an understanding of the current environment. The second is to map out what needs to be addressed for successful ICD-10-CM implementation. The ICD-10-CM project team for each department is responsible for ensuring the impact analysis is conducted in their department. Once the analysis is complete in all departments, the project team can analyze each department's needs and develop a budget for ICD-10-CM implementation.

The preliminary impact analysis is a good tool for assessing which areas may be affected most in the early stages of ICD-10-CM implementation. Vulnerable areas may include:

- Information systems
- Documentation
- Staff education needs
- Clinical and administrative

Analyze Information Systems

Conducting a system audit for ICD-10-CM compatibility is part of the impact assessment. Start by performing a comprehensive audit of all data systems currently using ICD-9-CM; and then analyze the systems that will use ICD-10-CM.

Your analysis should answer the following questions:

- How are ICD-9-CM codes used in each information system?
- Which vendor software applications—versus internally developed system interfaces, customizations and other affected software (like Charge Description Masters, practice management software, financial software, etc.)—are being used?
- How are codes entered? Are they manually entered or imported from another system or software?
- What is the current character length specification in the system? The 5010 conversion should resolve this problem.
- Can the system handle alphanumeric structure? It must.
- Can the codes, code descriptions, and supported documentation be obtained in a machine-readable format?
- Does the code format include a decimal?
- Can the current system house both ICD-9-CM and ICD-10-CM codes simultaneously?
- Will the vendor or internal information technology (IT) personnel be able to map forward from ICD-9-CM to ICD-10-CM and backward from ICD-10-CM to ICD-9-CM.
- How is the quality of data checked?
- How do the systems interface? (if applicable)

Once you perform a comprehensive audit of the IT systems, map the electronic data flow to inventory and all reports containing ICD-9-CM codes. Then perform a detailed analysis of necessary changes to be implemented for the transition to ICD-10-CM. You may need to contact software and hardware vendors during the analysis phase to identify potential costs that will affect your budget. Typical expenses may include the following:

- Hardware
- Software
- Upgrading systems
- Customization
- Staffing and overtime

Software modifications may include the following:

- Change to alphanumeric structure
- Longer code descriptors
- Field size expansion
- Edit and logic changes
- Use of decimals
- Table structure modification
- System interfaces
- Expansion of flat files containing diagnosis codes
- Redefinition of code values and their interpretation

Identify which forms and reports will need to be reformatted or revised. IT also needs to evaluate whether each system's storage capacity is sufficient to support both ICD-9-CM and ICD-10-CM during the transition or if the capacity will need to be increased. Also consider how long ICD-9-CM will be accessible, what staff will need to access ICD-9-CM, and how long the legacy data will need to be available.

Contact Vendors

Contact system vendors during this phase to determine whether they can support legacy and new coding systems and for how long. This is an ideal time to identify costs for upgrading software and storage capacity as well as contract issues with the vendor. This will help with the system conversion budget over the next several years.

Determine if upgrades are included in the current contract or if there are any additional costs. If upgrades are not included, inquire as to what costs will be incurred. Coordinate with the vendor the timeline for testing and installation of the new or upgraded software or system. Other IT system considerations might include a conversion to electronic health records (EHRs) or electronic medical records (EMRs) during this transition if the organization hasn't previously converted.

Assess Documentation

In the clinical area, the largest impact to ICD-10-CM implementation is documentation. Since ICD-10-CM is more robust and has up to seven digits of specificity, assess whether documentation currently in the medical record will support ICD-10-CM on the "go-live" date. Analyzing the documentation and conducting medical record documentation audits will enable you to assess the impact. The organization should have an experienced auditor(s) conduct audits either internally or externally. Random samples should be evaluated and various types of medical records should be reviewed. A clinical documentation assessment tool should be used to conduct this audit to be sure current documentation adequately supports ICD-10.

Take an in-depth look at the medical record's current level of documentation. Review the lack of specificity in the documentation and analyze how to begin the process of improvement. Based on the practice's specialty, review the most common diagnosis codes used and their frequency.

Once an audit is conducted and analyzed, the organization will have a good assessment of documentation deficiencies, and can develop a priority list of diagnoses requiring more detail. The audit also helps identify practitioners who will benefit from focused training using ICD-10-CM.

Implement a documentation improvement program within the organization and monitor the documentation on an on-going basis. This will ensure improvement and identify areas where practitioners are deficient and who needs more assistance. These audits should be conducted periodically to validate ICD-10-CM compliance. As with any audit, submit a report summary to senior management.

Coding and Billing Education

The key issue when assessing coding and billing in the impact analysis is education and training on the new ICD-10-CM code set. The organization must first identify who needs training, how many hours of training will be required, and the most beneficial training method. Questions to ask when determining training needs are below:

- How much training on ICD-10-CM will be necessary?
- How many training days will be required?
- Will there be lost revenue if the physicians and non-physician practitioners need to be out of the office for training?
- How will productivity be affected?
- How much training does each department need?
- What extent of training does each staff person need?

These are all valid concerns that need to be part of the impact analysis. Everyone in the medical practice will need some form of training. Physicians, non-physician practitioners (NPPs), coders, and billing staff will need

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more extensive training than ancillary staff (nurses, MAs, managers, etc.).

Some studies indicate less than 16 hours of training is necessary on ICD-10-CM. Physicians will need approximately 16-20 hours of training. Coders will need between 40-60 hours of training, with the ancillary staff and nurses needing six to 10 hours of training.

Training depends on the individual's understanding of anatomy, terminology, and ICD-9-CM. A person who is experienced in ICD-9-CM coding, with a good understanding of anatomy and terminology in their specialty, may take less time to train than a person with limited knowledge.

Physicians and managers are usually compensated based on revenue or salary, so overtime compensation will not be a consideration for this group. Coders and ancillary staff, on the other hand, typically are paid hourly rates. The recommended overtime budget is at a minimum of 15-20 hours pre-implementation and 20-40 hours post implementation. After implementation, work will increase due to system problems, denials, etc. Address these issues along with the daily business that occurs in a typical medical practice.

Figure Finances

Since reimbursement is tied to procedural and diagnosis coding, the finance area will be impacted greatly. For example, after the implementation date, if an insurance carrier cannot yet accept ICD-10-CM codes, the medical practice probably will not be paid. If your organization is not ready and cannot transmit claims, your practice's finances will be impacted as well. Review the current reporting for procedures and services using ICD-9-CM codes and compare them to ICD-10-CM codes. Professional services are paid based on the procedure code, but the diagnosis code supports medical necessity, which is the driving factor in payment for all medical procedures and services.

Reports tied to diagnosis codes, such as the accounts receivable analysis, pending claims reports, analysis by provider type, collection reports, etc., also will be impacted. Conduct an assessment of the reports currently impacted by ICD-9-CM and what impact will be realized with ICD-10-CM.

After implementation, the impact of such a major coding change will be felt and may be quite burdensome for practices. Pended or denied claims are expensive for practices to deal with, and generally are dealt with through a manual process. Any increase in the number of claims not processed or paid will first decrease provider cash flow, then increase both provider workload and plan workload to process the denials. Providers need to know the change in documentation and coverage requirements ahead of time to adapt in time for implementation.

For information on ICD-10 assistance within your practice or organization or to inquire about AAPC ICD-10 Implementation training for providers or health plans, contact Deborah Grider at deb.grider@aapc.com.

Next time: Organizing cross-functional efforts.

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