Tick, tock, tick, tock. Are you the only organization without an ICD-10 implementation plan? Survey says—no! As the clock ticks closer and closer to the implementation of ICD-10-CM and ICD-10-PCS in 2013, do you often wonder what everyone else is doing to prepare? Does the thought of such a major change make you want to consider retiring to the islands or changing professions altogether? Or are you ready for this challenge?

Three years seems like an eternity to prepare for this change, but is it really? On January 15, 2009, the U.S. Department of Health and Human Services announced that the current ICD-9-CM system will be replaced on October 1, 2013, with ICD-10-CM and ICD-10-PCS. For the official release in the Federal Register, see http://edocket.access.gpo.gov/2009/pdf/E9-743.pdf. This implementation date is for encounters and discharges occurring on or after October 1, 2013. CMS already stated in a June 2010 MedLearn Matters article (www.cms.gov/MLNMattersArticles/downloads/SE1019.pdf) that there will be no extensions.

ICD-9-CM to ICD-10-CM: The basics

Let’s take a moment to discuss the high-level changes. The ICD-9-CM diagnosis codes (Volumes 1–2) will be replaced by ICD-10-CM. This code set is used in any type of healthcare setting (inpatient, outpatient, and professional services) to identify why a patient encountered services. In some instances, the codes represent the causes of accidents, places of occurrence, and activities involved. Although the ICD-10-CM diagnosis codes will replace the ICD-9-CM diagnosis codes, they will be used in the same capacity as ICD-9-CM. Let’s explore some of the differences:

<table>
<thead>
<tr>
<th>ICD-9-CM*</th>
<th>ICD-10-CM*</th>
</tr>
</thead>
<tbody>
<tr>
<td>3–5 characters in length</td>
<td>3–7 characters in length</td>
</tr>
<tr>
<td>14,315 diagnosis codes</td>
<td>69,101 diagnosis codes</td>
</tr>
<tr>
<td>Only V codes and E codes start with a letter</td>
<td>ALL codes start with a letter</td>
</tr>
<tr>
<td>Limited space for adding new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Cannot identify laterality</td>
<td>Can identify laterality</td>
</tr>
</tbody>
</table>

* Based on the 2010 versions of ICD-9-CM and ICD-10-CM.

The biggest change is the sheer number of optional codes available to select a diagnosis. This increased specificity is helpful in identifying specific disease processes and the interaction between symptoms and definitive diagnoses.
General equivalence mappings, or GEMs, were created to determine how the ICD-9-CM codes map over (or, in some cases, how they do not map over) to the ICD-10-CM code set. There may not be a one-to-one ratio as traditionally seen with ICD-9-CM. There are many categories where one ICD-9-CM code may map to 10 different ICD-10-CM codes. Some code categories, such as coronary artery disease (CAD) (I25.xxx), will help resolve ongoing sequencing debates in ICD-9. One of these debates is whether to sequence CAD (414.0x) or unstable angina (411.1) first when both are present. In ICD-10-CM, there is a combination code to identify both conditions, as noted below. Situation solved!

I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris
Atherosclerotic heart disease NOS
I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris

Official Guidelines for Coding and Reporting and conventions
In addition to the structural differences of ICD-10-CM, there are a few convention changes in the Official Guidelines for Coding and Reporting. These guidelines are published by the four cooperating parties:

- American Health Information Management Association
- CMS
- National Center for Health Statistics
- American Hospital Association (AHA)


There are four significant changes to the conventions: placeholders, seventh character extensions, identification of laterality, and expanded applications of Excludes notes.

1. Placeholders. There are some codes in the ICD-10-CM code set that do not have a fifth digit but yet have a sixth and possibly a seventh digit or character. In order to accurately assign a code from that category, a placeholder of “x” must be used as the fifth character so additional characters may be appended. Examples of this are in the adverse effects and poisoning codes (T36–T50).

T36.4x5 Adverse effect of tetracyclines (Note: It would be incorrect to assign this category as T36.45, omitting the fifth character.)

2. Seventh character extensions. In addition to placeholders, some categories, such as T36.4x5, also require a seventh character extension to identify the encounter type. The most common seventh character extensions, along with what they identify, are as follows:
A—Initial encounter  
D—Subsequent encounter  
S—Sequela

T36.4x5A Adverse effect of tetracyclines, initial encounter

For codes such as fractures, the seventh character extension can add more specificity in regards to the type of fracture (closed versus open), the encounter type (initial versus subsequent), and even whether the healing was routine or complicated (e.g., delayed, nonunion, malunion).

3. Laterality. In ICD-9-CM, the codes are not capable of identifying on which side (e.g., right or left) a condition occurs. The guidance for ICD-9-CM tells us that each unique code can only be reported one time even if the condition affects bilateral sides. This can present problems in identifying conditions specifically and accurately. In CPT coding, procedures can be easily identified by appending modifiers such as -50 (bilateral procedure) or -RT (right side) and -LT (left side), but modifiers are not applicable on ICD-9-CM codes. In ICD-10-CM, separate codes can be assigned based on which side of the body is affected. As a comparison, ICD-9-CM code 274.01 (acute gouty arthropathy) identifies the nature (acute) and general location (joint) but not the specific site. In ICD-10-CM, the code will identify the type, specific location on the body, and right vs. left side, as noted below.

M10.011 Idiopathic gout, right shoulder  
M10.012 Idiopathic gout, left shoulder

4. Excludes notes – ICD-9-CM has one type of Excludes note, but the note can mean either of the following:
   ■ The condition in the Excludes note is not included in the code it is listed under and therefore should be assigned a separate code
   ■ The excluded term should be coded elsewhere

ICD-10-CM provides coders with more clarification by having two types of Excludes notes, as follows:
   ■ Excludes1 means “not coded here.” The code excluded should never be used in conjunction with the code/category above the Excludes1 note.
   ■ Excludes2 means “not included here.” The code excluded indicates the condition is not included in the category; therefore, if both conditions exist, two codes are necessary.

ICD-9-CM to ICD-10-PCS: The inpatient procedure coding makeover

The transition from ICD-9-CM Volume 3 procedure codes to ICD-10-PCS will be by all accounts a significant adjustment for coders. The ICD-9-CM procedure codes were fashioned in the same structure as the diagnosis codes.
by attempting to classify mostly based on body system, which in theory makes sense, but in practical use has its limitations. Here are some of the common differences between ICD-9-CM Volume 3 and ICD-10-PCS:

<table>
<thead>
<tr>
<th>ICD-9-CM*</th>
<th>ICD-10-PCS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>3–4 digits</td>
<td>7 alphanumeric characters</td>
</tr>
<tr>
<td>3,838 procedure codes</td>
<td>71,957 procedure codes</td>
</tr>
<tr>
<td>Lacks detail</td>
<td>Very specific</td>
</tr>
<tr>
<td>Limited space for adding new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Generic terms for body parts</td>
<td>Specific terms for body parts</td>
</tr>
</tbody>
</table>

* Based on the 2010 versions of ICD-9-CM and ICD-10-PCS.

You’ll immediately notice the tremendous increase in the number of procedure codes in ICD-10-PCS. It’s important to keep in mind that the ICD-10-PCS codes are only applicable for reporting inpatient facility services, just like ICD-9-CM Volume 3 procedure codes. Those who work in the professional services or hospital outpatient settings will continue to use the CPT and HCPCS II procedure codes.

The increase will enable organizations to capture the specificity of medical surgical procedures by identifying the following:
- The type of service or “section” (e.g., medical/surgical, obstetrics, imaging, nuclear medicine)
- Body system (e.g., gastrointestinal system, nervous system)
- Root operation (based off the objective of the procedure)
- Body part (e.g., ascending colon, descending colon)
- Approach (e.g., natural orifice, endoscopic, percutaneous)
- Device (e.g., intraluminal, extraluminal, external)
- Qualifier (e.g., diagnostic procedure)

In ICD-9-CM there are some procedures that may involve assigning multiple codes in order to describe the procedure fully. For example, to code for a percutaneous transluminal coronary angioplasty (PTCA) on one vessel with insertion of one drug-eluting stent, the following codes are required:
- 00.66 Percutaneous transluminal coronary angioplasty or coronary atherectomy
- 00.40 Procedure on single vessel
- 00.45 Insertion of one vascular stent
- 36.07 Insertion of drug-eluting coronary artery stent(s)

But to code for a PTCA with a drug-eluting stent in ICD-10-CM, only the following is required:
- 027034Z Dilation of coronary artery, one site with drug-eluting intraluminal device, percutaneous approach

ICD-10-CM uses a single comprehensive code to state what ICD-9-CM takes four procedure codes to describe.
ICD-10-PCS is fundamentally different in structure. It uses PCS tables for code assignment rather than a tabular list as seen in ICD-9-CM Volume 3. The alphabetic index will lead a coder to one of the PCS tables in order to create a procedure code. It is important to remember a valid PCS procedure code is made up of seven alphanumeric characters. See below for an example of what a portion of a PCS table looks like:

<table>
<thead>
<tr>
<th>Section</th>
<th>Body system</th>
<th>Operation</th>
<th>Medical and surgical</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2</td>
<td>7</td>
<td>Heart and great vessels</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dilation: Expanding an orifice or the lumen of a tubular body part</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1 Coronary artery, one site</td>
<td>0 Open</td>
<td>4 Drug-eluting intraluminal device</td>
</tr>
<tr>
<td>1</td>
<td>3 Coronary artery, two sites</td>
<td>3 Percutaneous</td>
<td>D Intraluminal device</td>
</tr>
<tr>
<td>2</td>
<td>4 Coronary artery, three sites</td>
<td>4 Percutaneous endoscopic</td>
<td>T Intraluminal device</td>
</tr>
<tr>
<td>3</td>
<td>5 Coronary artery, four or more sites</td>
<td>5 Drug-eluting intraluminal device</td>
<td>Z Radioactive intraluminal device</td>
</tr>
<tr>
<td>4</td>
<td>6 Drug-eluting intraluminal device</td>
<td>6 Drug-eluting intraluminal device</td>
<td>Z No device</td>
</tr>
<tr>
<td>5</td>
<td>7 Drug-eluting intraluminal device</td>
<td>7 Drug-eluting intraluminal device</td>
<td>Z No device</td>
</tr>
</tbody>
</table>

Implementation planning: Where do organizations stand?

Now that you see the big differences between the two coding systems, let’s move on to what’s happening in the field. In June 2010, HCPro, Inc., conducted a survey of HIM directors in hospitals across the country, garnering responses from almost 400 facilities. The survey asked questions about how teams are preparing for implementation and what concerns are most pressing regarding the 2013 transition.

The survey found that the vast majority of respondents (91%) are aware of the change to ICD-10 but that most (70%) have not taken any action to prepare. Ideally, the process should begin with the formation an ICD-10 implementation team or committee. This committee should have key leaders or representatives from all areas that use or assign coded data (HIM, HIS, patient registration, finance, clinical documentation improvement programs, medical directors and/or physician advisors, clinical areas). It will be beneficial to have representatives from the affected areas (in truth, almost every department is an affected area) to make sure all are aware of the new code set’s impact and understand its complexities; this will help determine how the change will affect the organization as a whole. The survey found that just 33% of the respondents either have a team or are in the process of forming one.

Sixty-four percent of survey respondents said their HIM director is the key leader in their process and plan. Once the committee has been formed, it will be up to the members to determine an overall ICD-10 implementation plan.
Less than 30% of organizations said they have developed their implementation plan at this point in time.

To jumpstart the implementation, all organizations should perform an ICD-10 impact assessment. Although the survey showed that most (78%) have barely begun, the assessment process is a vital step to determine where change will be necessary to accommodate and optimize the use of ICD-10. Key components should include the HIM coding and reimbursement systems (such as encoding systems, DRG groupers, and case-mix systems) but also billing, claims, and registration systems as well as other clinical departments such as pharmacy, tumor registries, and ancillary services.

How would you describe your organization’s level of knowledge and current state of readiness related to ICD-10?

<table>
<thead>
<tr>
<th>Description</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>No understanding of ICD-10 and its effects on the organization</td>
<td>31 8%</td>
</tr>
<tr>
<td>Aware of the change in code sets, but we haven’t taken any action</td>
<td>260 70%</td>
</tr>
<tr>
<td>Aware of the change and actively engaged in implementation</td>
<td>79 21%</td>
</tr>
</tbody>
</table>

Source: HCPro ICD-10 Implementation Planning Survey.

Does your facility have an ICD-10 implementation team/committee?

| Description                                                      | Percent | |
|------------------------------------------------------------------|---------|
| Yes, we have a team in place.                                     | 65 18%  |
| Yes, we are in the process of forming a team.                     | 54 15%  |
| No, but we intend to form a team soon.                            | 115 31% |
| We have no plans to form a team at this time.                     | 111 30% |
| I don’t know.                                                     | 25 7%   |

Source: HCPro ICD-10 Implementation Planning Survey.

What areas are you most concerned about as they relate to ICD-10 implementation? Choose all that apply.

| Description                                                      | Percent | |
|------------------------------------------------------------------|---------|
| Information technology                                           | 163 44% |
| Physician documentation                                          | 223 60% |
| Coder training                                                   | 238 64% |
| Budget                                                           | 131 35% |
| Other, please specify                                            | 37 10%  |

Source: HCPro ICD-10 Implementation Planning Survey.
Concerns

The HCPro survey found providers are most concerned about three key areas:

1. **Training for physicians and coders.** It’s no surprise that with change comes the need to alter habits and applications that have been used for many years. Even though the code set will not be applicable until 2013, it’s beneficial to begin applying its general concepts now.

According to the survey, the top five methods that organizations will use to train their staff are:

- Audio conferences or webcasts
- Books and handbooks
- E-learning courses
- In-services led by in-house trainers
- Conferences/boot camps

In addition to the methods above, other practical strategies to train coders and clinical documentation specialists for the transition include:

- “Lunch and learn” sessions in which the coders are provided ICD-10-CM and ICD-10-PCS (if applicable) coding books to code chapter-specific case studies in ICD-10. One month might cover gastrointestinal diagnoses and procedures, the following month might cover obstetrics diagnoses and procedures, and so on.
- Coding assessment tools that reinforce and test knowledge of medical terminology, human anatomy, and sequencing per the *Official Guidelines for Coding and Reporting*.

Training physicians can be complicated because from a professional standpoint, they will only need training in the ICD-10-CM diagnosis codes. However, if they perform procedures on inpatients, they will also need guidance on the ICD-10-PCS system to avoid incessant queries asking for clarification. Practical strategies to train physicians for the transition may include the following:

- For professional services only, host brief (30-minute) lunch meetings with physicians. During the meetings, review the top 25 most commonly used diagnosis codes per specialty and convert them to ICD-10-CM. The review should discuss any additional documentation that will be necessary and devise ways to update charge sheets that will work from both a clinical standpoint as well as a billing/coding perspective. There is no harm in adding specificity to documentation now in preparation for ICD-10-CM, even if it does not affect the assignment of codes under ICD-9-CM.
- For surgical specialists for inpatient services, the HIM department may opt to review the top 10 inpatient procedure codes and the current operative reports (preferably by specialty) to identify added documentation that may be necessary for accurate coding in ICD-10-PCS. Again, the added documentation may not
It is important for organizations to invest and plan for this change by setting aside funds for education and technology—starting now, not just in the year preceding the implementation.

affect code assignment in ICD-9-CM, but making the change now means the added documentation will become a habit by the implementation date.

2. Productivity. **Productivity.** A few respondents mentioned that productivity is their major concern. These days, coding is not unlike other fields: There are more responsibilities and expectations of increased productivity. There is no doubt that the transition will be a bit of a challenge at first. Most seasoned coders have so many codes memorized that they can often either write down the code or bypass the decision tree in an encoding system or other coding software program for some of the most common codes, which saves time on code assignment and speeds up the process. Many seasoned coders may be thinking to themselves, “How will I memorize all the specificity in these new codes?” We’ll have to say goodbye to the days of hypertension (401.9), diabetes mellitus Type 2 (250.00), and Afib (427.31). Still, coders will likely eventually be able to memorize some of the commonly used ICD-10 codes, in the same way we did with ICD-9-CM.

3. Budget. **Budget.** When ICD-10 was originally announced as the system that would replace ICD-9-CM, it’s likely a number of people immediately thought about the costs involved in such a major overhaul. Most survey respondents stated that they don’t know how the implementation will be budgeted or whether a specific implementation budget exists. Regardless, it is important for organizations to invest and plan for this change by setting aside funds for education and technology—starting now, not just in the year preceding the implementation. If your ICD-10 implementation team or HIM director has not held a meeting with all of the organizational leaders—including but not limited to the CEO, chief financial officer, and chief information officer—now is the time to convene one. This system is not just a possibility—it is reality.

In addition to what was cited in the survey results, another concern that coders will face is the lack of reliance on historical coding guidance. Coders have relied on the AHA’s Coding Clinic for ICD-9-CM as a supplemental resource to the Official Guidelines for Coding and Reporting since 1984. Coding Clinic for ICD-9-CM contains a plethora of information and guidance about sequencing and coding that has become an integral part of proper code assignment. This source authority is often used as an optional resource in encoding systems such as 3M; additionally, it is commonly cited as the basis for code assignment in the face of audits (internal and external) and other coding accuracy reviews. Many wonder what will happen to the almost 30 years’ worth of guidance when ICD-10 is implemented. The AHA recently released a statement saying that it has no plans to convert all or even part of the advice previously published in Coding Clinic for ICD-9-CM. Instead, the AHA has started a new newsletter that solely addresses ICD-10-CM and ICD-10-PCS issues. It will be titled AHA’s Coding Clinic for ICD-10 Briefings. The AHA felt that the questions and advice contained in Coding Clinic for
ICD-9-CM are only applicable to the ICD-9-CM code set and would not translate to the ICD-10-CM and ICD-10-PCS code sets.

Updates to ICD-9-CM and ICD-10-CM/ICD-10-PCS
As time passes and the implementation date nears, you may wonder what will happen between now and then regarding updates to ICD-9-CM and ICD-10-CM. Per the Medicare Prescription Drug and Modernization Act of 2003, codes can be added two times per year: April 1 and October 1.

Having two updates per year enables new procedures to be identified quickly. Note that April 1 updates do not require payment methods (e.g. MS-DRGs) to be updated until October 1.

The entity responsible for the revisions and additions to the ICD-9-CM code set is the ICD-9-CM Coordination and Maintenance Committee. The current proposed schedule for ICD-9-CM and ICD-10-CM/PCS updates, based off the March 2010 ICD-9-CM Coordination and Maintenance Committee meeting, is as follows:

- October 1, 2011—Last regular update to ICD-9
- October 1, 2012—Limited updates to ICD-9 and ICD-10
- October 1, 2013—Limited updates to ICD-10
- October 1, 2014—First major update to ICD-10

Note that the 2012 and 2013 updates will accommodate new technology and diseases only.

“The final decisions regarding the update schedule and content are made at the ICD-9 Coordination and Maintenance Committee meetings. To review the final decision, please visit the CMS website at www.cms.gov/ICD9ProviderDiagnosticCodes/03_meetings.asp#TopOfPage, where all the meeting minutes are posted.

Prepping for ICD-10-CM and ICD-10-PCS will be one of the most exciting times to be working in the healthcare industry. Healthcare organizations should begin the acclimation to the new code sets, form an ICD-10 implementation team, and develop an ICD-10 plan (which should include an assessment of the organization’s needs in relation to ICD-10).

It may be a challenge to determine what type of training should be provided to your employees, and the training you decide on may need to be customized to match your employees’ exposure to ICD-10 and the specific applications they use. Productivity may drop slightly while the new codes are being learned, so adjusting staffing may be necessary for the short term. But there’s no doubt that seasoned coders will be using ICD-10 proficiently and effectively—just like ICD-9—in no time. It will be like every October 1 when new codes are added; many times we don’t find the problems with the codes or the payment methodologies (MS-DRGs, APCs, or professional services) until the codes are
actually assigned and processed. We’ll need to rely on definitive advice con-
tained within the Official Guidelines for Coding and Reporting and the AHA’s
Coding Clinic for ICD-10 Briefings for guidance on ICD-10. Just remember
the famous Boy Scout motto: “Be prepared!” Start training and planning in the
years leading up to implementation, and you’ll be ready to go on the big day.

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com/courses/10047/overview). Shannon is an AHIMA-certified ICD-10 trainer.
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- Explain the new structure for procedure coding for inpatient services
- Categorize procedures by root operation
- Master the use of ICD-10-PCS tables
- Identify the benefits of transitioning to ICD-10
- Apply new conventions in the ICD-10-CM coding guidelines

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- Sign up for the online two-week version of the ICD-10 Basics Boot Camp, classes beginning in March 2011.

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