Physicians are Key to ICD-10 Success

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From primary care physicians to hospitalists and specialists, all physicians in all health care settings are going to be affected by the transition to ICD-10—if they haven't already. And with the October 1, 2014 compliance date just around the corner, it's important that physicians are prepared. A lack of compliance will result in a direct hit to a practice's revenue cycle, productivity, and quality data.

ICD-10 is arguably one of the biggest changes to health care in decades. With significant administrative and financial implications, its implementation is a massive undertaking for practices. Proponents believe ICD-10 will improve the ability to measure health care services provided to patients, enhance clinical decision-making, track public health issues, conduct medical research, identify fraud and abuse, and design payment systems to ensure services are reimbursed appropriately. But it is not without controversy.

Physicians, hospital administrators, organized medicine, and others have voiced many concerns, particularly that the increase in the number of diagnosis codes—from 14,000 in ICD-9 to about 69,000 in ICD-10—make ICD-10 too complex and difficult to use. Implementation was delayed a year to allow more time to prepare, but the Centers for Medicare and Medicaid Services has made it clear the deadline will not be extended a second time.

Although the ICD-10-CM diagnosis code set is substantially larger than its predecessor, ICD-10 is not that radically different. ICD-10 codes are, however, more precise. As such, they promise to provide more accurate information about the patient, which in turn will justify medical necessity for utilization of goods, services, and complex procedures and should decrease the need to include supporting documentation with claims.

Currently, insufficient documentation results in inaccurate reimbursement, higher probability for audit recoveries, and poorly demonstrated quality of care. Less specificity in ICD-9 codes often results in physicians not receiving appropriate credit for treating more complex cases. The medical record needs to link symptoms, complications, and manifestations to disease process, ultimately demonstrating medical necessity and clinical appropriateness for ordering and rendering services. The physician who picks up the patient record should have a clear, concise picture that identifies exactly what was done for the patient, including outcomes, orders, and other information needed to provide continuing care. The more specific documentation required with ICD-10 will drive more appropriate reimbursement across the spectrum.

There are a number of resources available to help practices prepare for ICD-10. *(See box.)* And because detailed physician documentation is the foundation of ICD-10, the Wisconsin Medical Society has prepared a webinar series specifically for physicians. *ICD-10: What Physicians Need to Know,* is a 30-minute introductory program available online, on-demand that addresses the fundamentals of ICD-10. There are also sessions available for 20 different specialties that delve into the details necessary for specified diagnosis code assignment relevant to each of those specialties. Information is available on the Society's website at www.wisconsinmedicalsociety.org/resources/icd-10.

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ICD-10 Resources

Wisconsin Medical Society
(https://www.wisconsinmedicalsociety.org/resources/icd-10/)

American Medical Association
(http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act/transaction-code-set-standards/icd10-code-set.page?)

Centers for Medicare & Medicaid Services
(https://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10/)

American Health Information Management Association
(http://www.ahima.org/icd10/)

Wisconsin ICD-10 Task Force
(http://www.wicd10.org/)

American Academy of Professional Coders
(http://www.aapc.com/ICD-10/

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