INTRODUCTION
Physicians are a courageous breed, yet they are not without their own fears. For some, one of those uncertainties centers on ICD-10, as they are overwhelmed with the enormity of the change, unsure of their role in implementation and wary of the consequences of the new coding structure.

This white paper looks at these concerns, addressing their reservations. It also delineates the role ICD-10 can play in the improvement of patient care and underscores the importance of physicians in effecting the change to that end.

“IT’S TOO BIG AND COMPLEX”

Numbers don’t lie: ICD-10-CM/PCS represents a huge change. ICD-10 is intended to provide greater detail in describing illnesses, injuries and procedures than ICD-9, and it certainly does. ICD-9 uses codes of up to five characters to describe 14,000 diagnoses and 3,000 inpatient procedures. By contrast, ICD-10 codes will contain up to seven digits or letters to describe about 68,000 diagnoses and 87,000 procedures.

However, as pointed out by the Centers for Medicare & Medicaid Services (CMS), just as adding words to a dictionary doesn’t make it more difficult to use, the greater number of codes in ICD-10 doesn’t necessarily make it more difficult to navigate.¹

It’s all a matter of perspective.

First, as has been reported, there are many codes – and permutations of those codes – that individual physicians never will use. After all, the chances of a patient being bitten by a pig while in a prison swimming pool or being struck by an orca on more than one (or even one) occasion are highly unlikely.

Next, specialists and other practitioners with defined populations will need to deal with far fewer codes than physicians with a broader range of patients and responsibilities.

In addition, as noted in Hospital and Health Networks (HHN) Daily, the growing number of hospital-based physicians won’t face the same level of preparation as their office-based colleagues, as they will have hospital coders, clinical documentation improvement specialists and case managers to instruct them prospectively and query them concurrently.²

Summary
Physicians’ concerns surrounding ICD-10 are understandable. So much is happening in health care today that they’re being pulled in more directions than ever.

In the case of ICD-10, it is important that physicians understand that the task before them is surmountable and appropriate training exists to help. It also is essential that they truly comprehend how critical they are to a successful transition and the difference their participation can make.


A great deal of the angst can be removed by identifying the codes the practice or organization uses the most and putting initial focus there. One way to determine this critical code mass is a review of super bills.

Oft-quoted figures also demonstrate the large groupings of codes within ICD-10 that can be pulled away from the whole to make it more manageable. For instance, 50 percent of all ICD-10CM codes are related to the musculoskeletal system, 25 percent are related to fractures and more than 35 percent pertain to laterality. This means, CMS has stated, that only a small percentage of the codes will be used by most providers.

In addition, CMS asserts: "...just as you don’t have to search the entire list of ICD-9-CM codes for the proper code, you also don’t have to conduct searches of the entire list of ICD-10-CM/PCS codes. The Alphabetic Index and electronic coding tools are available to help you select the proper code... Because ICD-10-CM/PCS is much more specific, is more clinically accurate and uses a more logical structure, it is much easier to use than ICD-9-CM."³

"IT WILL COST TOO MUCH TO PUT INTO PLACE."

Yes, there are costs involved. How much those costs will be, however, is dependent upon a number of factors, from practice size and circumstances to how well an organization has managed all the elements of integration.

It also depends on who is providing the estimates, as projections by ICD-10 advocates and opponents vary greatly. For instance, as reported by Medical Economics, an AHIMA study put the cost for a three-person physician practice in the range of $1,960 to $5,900. That contrasts with a report prepared for the American Medical Association that predicted small-practice conversion costs will range from $22,500 to $105,500.⁴

And, for the employed physician, cost is not really a direct issue.

While there will, indeed, be outlays, there also are significant predicted gains. For instance, a Rand Corp cost-benefit study pointed to the plus side of the ledger, such as:

- More-accurate payments for new procedures
- Fewer miscoded, rejected and improper reimbursement claims
- Better understanding of the value of new procedures
- Improved disease management

There also is the immense potential gain of improved outcomes. This same information gleaned under ICD-10 also can drive more effective cost analyses, identifying ways to curb health care expenditures and better allocate resources.

Again, preparedness is key – for providers, their staffs, their payers and their vendors.

“IT WILL CHANGE THE WAY I PRACTICE MEDICINE.”

ICD-10 codes are descriptors; they are not the stuff of a how-to manual. And, while it is important that new concepts inherent in ICD-10 be documented, this documentation is meant to create a more complete clinical picture. The additional, more specific information could, indeed, impact treatment decisions, but more likely promote more targeted and better care.

This also could lead to more focused evidence-based practice and a more effective relationship between a patient and a physician, who can now know more specifics about that patient as an individual, not just as a member of a group.

“THERE ARE TOO MANY OTHER COMPETING PRIORITIES.”

Another concern is that ICD-10 implementation comes at a time when practices and health care organizations are implementing electronic health records (EHRs) and facing many other new mandates, such as meaningful use. The sheer bulk of these requirements, it is feared, could be overwhelming.

AHIMA suggests otherwise. As stated by the association’s Manager of Professional Practice Resources Kathy DeVault, many of these initiatives come together.

For instance, she said “A lot of EHR systems and computer-assisted coding tools are designed with ICD-10 in mind. The ICD-10 codes help build that meaningful use of data. [Y]ou can’t look at these things in silos. ICD-10 really needs to be looked at as a convergence of projects that all work together to improve quality of care. They work in concert with each other, not in competition.” And, it might be added, work to improve revenue through eligibility for incentives.

“In fact, according to AHIMA, without ICD-10, the return on investment in electronic health records and health data exchange will be greatly diminished.

“With less than a year until the one-day ICD-10 conversion . . . a physician’s ultimate life preserver is going to be planning and training.”

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6 Making a Smooth Transition: Avoiding the Top 5 Risks of the ICD-10 Conversion. AHIMA.
6 https://ehrintelligence.com/2013/01/16/ahima-cms-respond-to-ama's-continued-icd-10-resistance
7 http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/billing/icd-10-countdown-how-your-practice-can-get-ready
“IT WILL NEGATIVELY IMPACT MY INCOME”

This fear manifests in a number of ways, including concerns that incorrect coding choices will result in decreased, or no, payments and that the new coding system will cripple productivity.

Reimbursement

Many stakeholders have been encouraged by the end-to-end ICD-10 testing conducted by CMS from Jan. 26 through Feb. 3, 2015, with findings that showed positive results and pointed out areas that can be addressed before implementation.8

The testing showed that 81 percent of submitted test claims were accepted during the first ICD-10 end-to-end testing initiative. A total of 661 health care organizations, including providers, clearinghouses and billing agencies participated. Collectively, they submitted 14,929 ICD-10 test claims of which 12,149 were accepted.

In praise of results, the ICD-10 Coalition advocacy group stated that, with seven months remaining to correct issues discovered during testing, “the high rate of successful submission of ICD-10 codes is especially encouraging for physician offices since more than half the claims submitted for end-to-end testing were professional claims. Of the 19 percent of rejected claims, 16 percent were rejected due to errors unrelated to ICD-10, including incorrect National Provider Identifier, incorrect Health Insurance Claim Number, incorrect Submitter ID, date of service outside the range valid for testing, invalid HCPCS codes and invalid place of service.”

It also is important to note that, unlike ICD-9, ICD-10 was developed with reimbursement in mind. Thus, according to Medical Practice Insider, ICD-10 provides “a more decisive system to determine payments by offering greater detail on the quality of the care provided” and “more diagnostic choices to capture new data to ensure they are paid for the complex work they perform.”

Silver Linings

This complexity, when properly leveraged, also can save time and money, according to American Medical Software (AMS) online. For instance, providers who “can tell a health plan the activity, location and work status of the patient when they were injured, chances are [their] claims can be automatically adjudicated with no additional record requests required, easing the administrative burdens that are normally required.”9

The greater ability to show severity, AMS also stated, may simplify prior authorization or eliminate the need for an appeal, saving the physician and staff valuable time and reducing payment delays.

9 http://americanmedical.com/2012/10/top-5-reasons-why-icd-10-is-nothing-to-fear/
Additionally, it has been asserted that ICD-10 has a much greater capability to curb health care costs by more precisely and efficiently describing a patient’s illness, spurring accelerated diagnosis and treatment.

And a good job will be rewarded. The CMS Physician Compare web site and private insurance tiers designed to help consumers make informed choices about providers will influence prospective patient decisions on where to access care and also impact the inclusion of payer contracts and preferred networks. For proceduralists, as stated on HHN Daily, “the accuracy and specificity of ICD-10 will impact risk-adjusted measures of clinical quality and, ultimately, access to patients.”

Maximizing Income Opportunities

While working toward a smooth ICD-10 transition, health care organizations also should keep in mind the aforesaid incentives that can be earned under certain mandates and take advantage of other available income opportunities.

For primary care physicians (PCPs), particularly, one option could be found in the new Medicare payment system for Chronic Care Management (CCM) services. The 2015 Medicare Physician Fee Schedule (PFS) includes a Current Procedural Terminology (CPT) Code – 99490 – that pays for clinical staff time, directed by a physician or other qualified health care professional, in “developing and implementing a care plan for a patient with at least two chronic conditions that are expected to last at least 12 months or until the death of the patient; or that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.”

Payment is $42.60 for 20 minutes of staff time. The code can be billed once per patient per calendar month

This means that a practitioner with a significant number of such patients potentially could gain hundreds of thousands of dollars annually by documenting their care plans for these populations.

A 2013 study by U.S. Department of Health and Human Services found that about 25 percent of the nation’s adult population had multiple chronic conditions, and the care they required accounted for 66 percent of the nation’s health care spending. A study done for the same year by the Centers for Disease Control and Prevention reported that the two-thirds of Medicare beneficiaries with two or more chronic conditions accounted for 93 percent of Medicare spending. Under the 2015 Medicare Physician Fee Schedule, these large numbers could mean significant income for those who serve these populations.

This new source of income for PCPs could counter the costs associated with ICD-10 implementation, while putting practitioners in place to achieve appropriate reimbursement in the new coding system.

“IT WILL TAKE TIME AWAY FROM PATIENT CARE.”

Again, this should not be a great concern if everyone relevant to the coding and documentation process is adequately trained and working as a team to support each other’s efforts.

In fact, it has been asserted by ICD-10 proponents, quite the opposite may result. With a system that more precisely describes the patient encounter and more accurately defines co-morbidities, complications and disease manifestations, better treatment can be delivered more efficiently and more quickly for improved outcomes and patient satisfaction. This phenomenon could result from a variety of factors, including:

• Improved analysis of risk and severity of illness
• Improved population epidemiology
• Improved outcomes analysis
• The accumulation of diagnostic data for physicians, practices and hospitals
• Granularity to support development of new quality-based, data-driven protocols
• Enhanced detail on socioeconomic, lifestyle, etc., that draws a clearer picture, enabling more individualized care
• The positive impact its specificity could have in public health syndromic surveillance initiatives that now use ICD-9 coded data to drive decisions on health policy and education.

“I DON’T HAVE THE TIME TO LEARN A NEW SYSTEM.”

For clinicians, time is an extremely important commodity. Thus, it is not surprising that some physician pushback on ICD-10 transition is based on the time it would take to get a grasp of the new system.

“The more precisely we document and code, the more precise the data will be that’s mined from EHRs to elucidate gaps in care. By painting a more accurate picture of individual and aggregate attributed patients, ICD-10 potentially will enhance a physician’s ability to do population management.”

Since clinical documentation stands at the hub of a health care organization’s ability to effectively manage care, as well as protect its financial viability, it is important that everyone involved in documentation be trained in ICD-10 – including physicians.

And while training admittedly takes time, the right training can take far less time and be far less intrusive than clinicians might expect.

Such training solutions offer concise, practice-specific lessons delivered online for anytime access. The best of the breed focus on the necessary documentation elements for high-risk, high-cost, audit-related or ICD-10-related conditions and pinpoint the fundamentals needed to support admission; justify diagnostic work-up, treatments and services; and accurately reflect a patient's severity of illness.

More in-depth training can provide physicians with insight into why certain diagnosis codes are selected and help providers identify critical documentation requirements based on settings and type of service provided.

Physicians who have not as yet availed themselves of such easily accessible and targeted training should do so – and now.

Comprehensive, cohesive, role-based training across the organization teaches how to tell a story of what was done, get paid appropriately and ensure that quality data is available for disease profiling, research, education, public health programs, development of standards and protocols and much, much more.

NARROWING THE BROADER VIEW

We all are familiar with more global arguments for ICD-10, which finally puts the United States in a position to compare and contrast data with other developed countries across the world.

Cited benefits include:

• Global best practices from which to draw
• An enhanced ability to track public health conditions and concerns
• The ability to respond more effectively to deadly disease outbreaks
• Better response to/defense against weaponized bioterrorism
• Capability to conduct worldwide apples-to-apples research

At the end of the day, however, a physician’s world is usually far more circumscribed, with a focus on individual patients. Thus, while the idea of medical data that easily transverses borders is compelling, it is its benefits in daily use that could drive its success in the United States.

12 http://justcoding.com/282408/redirect
THE FOCUS ON PHYSICIANS

In all likelihood, ICD-10 will continue to roar toward us, and physicians must not only get on board but also stoke the engine. They can do this in a number of ways.

First, it is imperative that they attain the proper training to empower coders with the high-quality documentation it will take to support ICD-10 compliance, appropriate reimbursement and value-based purchasing, among other mandates and requirements.

Next, physicians are leaders and role models. Their acceptance of the benefits of the new coding structure and their willingness to get involved in its efficient implementation can go far in creating the high-performance team it will take to effect this massive change.

Also, physicians have the most responsibility – not only for their ongoing practice of medicine but also for delivering the quality of care that fosters a good reputation and financial viability for their organization.

Finally, it is important to acknowledge that a lot has happened in medicine and technology during the past 30 years. ICD-9 can’t reflect that change and promote ongoing improvement. ICD-10 is one way to advance medicine here and across the world. And that is another reason not only to get engaged but even be enthusiastic.