Call to Action: Start Preparing for ICD-10-CM

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As you probably know, the deadline for implementation and compliance with ICD-10-CM was originally set for Oct. 1, 2013. Recently, the US Department of Health and Human Services announced a final rule that will delay the compliance date until Oct. 1, 2014. What does this delayed date mean for wound care providers? You have been granted additional time to:

- ensure that you have a solid documentation improvement program,
- analyze your data for areas of concern,
- audit your medical records,
- examine your workflow,
- communicate with your computer vendors,
- revise your forms and templates, and
- integrate new documentation requirements into practice—regardless of work setting.

Do not waste this precious gift of extra preparation time. The US Centers for Medicare & Medicaid Services (CMS) has predicted that most health systems and professional practices needed 4 years of preparation time. If you have not begun, you now have 2 years to accomplish the many steps involved in the implementation of ICD-10-CM. The purpose of this article is to provide a basic understanding of the coding and documentation changes that you must start to implement.

**BENEFITS OF ICD-10-CM CONVERSION**

One of the main benefits of ICD-10-CM is that disease classifications will be consistent with current clinical practice and medical technology advances. The new classification codes will be very granular, which means the level of specificity will greatly improve. Numerous new codes will represent more specific anatomic sites, etiologies, comorbidities, and complications, and they will improve the provider’s ability to demonstrate severity of illness.

For instance, the new feature of laterality is directly built into the new codes: separate codes will distinguish right, left, and bilateral, where needed. The increased granularity will provide better analysis of disease patterns and outbreaks of disease. Additionally, the US will be using the global diagnosis coding system.

The current ICD-9-CM system consists of approximately 13,000 codes and is running out of numbers. The new ICD-10-CM system is expanding to approximately 68,000 codes and has flexibility for expansion. ICD-9-CM codes have 3–5 characters that are numeric, with the exceptions of the “V” codes (Factors Influencing Healthcare), “E” codes (External Causes of Injury), and “M” codes (Neoplasm Morphology) that begin with a single letter. The new ICD-10-CM codes have 3–7 characters that are alphanumeric. To take advantage of ICD-10-CM, all medical professionals, coders, billers, etc. must have a basic understanding of the differences between ICD-9-CM and ICD-10-CM (eg, code formats, code descriptions, and ICD-10-CM coding instructions. Many seminars pertaining to these basics are offered by numerous vendors, professional associations, and payers. All wound care professionals should attend ICD-10-CM workshop(s) that pertain to their medical specialty(ies).

**PREPARING FOR CONVERSION**

Clinicians should take the lead and form task forces with representation from all disciplines involved in wound care that own responsibility for full implementation of ICD-10-CM. Teams should meet frequently over the next 2 years to create and implement “to do” lists that include tasks such as reviewing computer systems, documentation forms, documentation habits, and auditing data (forms and processes) as well as educating providers on how to meet the specificity of the ICD-10-CM coding system.

The task force may choose to conduct an operations assessment that will identify where the various components of the medical record come from, who generates the medical record information and documentation, and who updates the electronic health record (EHR) templates and software or paper-based medical record documents. Reviewing current documentation practices, especially of the most frequent diagnoses seen, and improving providers’ documentation are the most important ICD-10-CM preparation steps. This documentation improvement process will benefit your practice immediately and assist with preparation for increasing the specificity of ICD-10-CM diagnosis coding. With proposed ICD-10-CM codes frozen until 2014 implementation, the documentation practices that providers implement today will still be in effect 2 years from now.

Currently, various payers (including
Recovery Audit Contractors and Office of the Inspector General are auditing wound care practices for inadequate justification of medical necessity. Therefore, scrutinizing medical record documents and the diagnostic information contained on each document is crucial in beginning a documentation improvement process. Reviews should also be done for all documentation requirements set forth by JCAHO, state departments of health, medical staff rules and regulations, and documentation requirements in pertinent Medicare National Coverage Decisions (NCDs) and Local Coverage Determinations (LCDs). CMS has released several NCDs while Medicare Administrative Contractors have released numerous LCDs pertinent to wound care services, procedures, and products. For example, many NCDs and LCDs state that wound care physicians must document failed conventional wound care before Medicare will cover the use of more advanced procedures and products. When reviewing the diagnosis driven medical record, ask yourself the following questions:

• Where can you find historical information about your patients?
• Where can you find referrals from the referring physicians?
• Where can you find discharge summaries?
• Where can you find the most current problem lists?
• Where can you find consultation reports?
• Where can you find outpatient medical records? Are they electronic or are they paper-based?
• What processes are in place to obtain past medical records if the patient doesn't bring them to the first appointment?
• Does the EHR carry forward diagnosis information from visit to visit inappropriately?
• Are your registrars, rather than your physicians, currently assigning the ICD-9-CM codes that are used on the claim forms?

Performing self-audits of documentation practices, departmental/institutional processes, actual coding, and denied claims will identify problem areas where the medical team should focus its attention. If coders are available to assist with self-audits, ask for a frequency listing of diagnosis codes seen in practice. These are the codes for which one should learn the new ICD-10-CM codes and the documentation required to support them. When reviewing common diagnosis codes, pay particular attention to any “not otherwise specified” and “unspecified codes.” These codes usually end in .8 or .9. Just as their descriptions infer, these unspecified diagnoses should be areas of concern. If documentation in the medical record was not specific enough to assign an ICD-9-CM code, accurate coding of any diagnosis in the ICD-10-CM system won't be possible. Start training now to prevent queries, which coders dislike requesting and physicians dislike receiving.

If providers focus on improving documentation for diagnoses treated, they will have more robust medical justification for their work in the ICD-9-CM system and they will prevent long delays in processing claims when transitioning to ICD-10-CM. When ICD-10-CM begins, coders will not be able to process claims for medical records that do not contain specific documentation that leads to a specific diagnosis code. In these cases, coders will have to stop the claim and query the provider for more specific documentation. Education of all wound care professionals who document in the medical record will be key to developing excellent documentation habits that support specific ICD-10-CM codes. To accomplish this, identify a practice “champion” who is passionate about ICD-10-CM and is willing to educate others on how to properly document.

**POINTS TO PONDER FOR CONVERSION**

- All providers will likely uncover many areas that need to be addressed in order to smoothly transition to ICD-10-CM. When combining the wound care clinician's responsibility for providing high-quality care as patients move throughout the healthcare continuum with the required documentation to support medical necessity via ICD-10-CM, we all must understand the importance of maintaining a longitudinal medical record that is easily accessible for all providers and payers.

As you begin ICD-10-CM conversion, consider the following:

- Plan to run ICD-9-CM and ICD-10-CM simultaneously for an agreed upon timeframe by the implementation team because bills that aren't dropped prior to conversion will need to use ICD-9-CM. Pre-ICD-10-CM claims that must be re-billed will require ICD-9-CM codes. Some facilities may choose to run dual systems for training and computer testing purposes.
- Budget for outside services that will most likely be needed to assist with the conversion.
- Evaluate the efficiency of information flow from registration to billing and from billing to remittance notice.
- Anticipate that multiple ICD-10-CM codes may be required to fully describe some medical conditions while other ICD-10-CM codes may represent multiple medical conditions in a single code.
- Assess skill levels of individuals performing the coding function.
- Train the entire professional wound care team on comprehensive, specific documentation.
- Monitor your clinical documentation improvement program and communicate your successes and opportunities for improvement to the entire staff.
- Develop a query program that requests clarification regarding non-specific documentation from providers.
- Use metrics to show each medical professional's documentation improvement.
- Review how claim denials are currently handled.
- Determine if additional staff will be required to handle ICD-10-CM conversion.
- Evaluate how the transition will affect your EHRs or paper records. Do forms and electronic screens need to be revised?

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Apligraf® Essential Prescribing Information

Device Description: Apligraf is supplied as a living, bi-layered skin substitute manufactured from cells processed under aseptic conditions using neonatal foreskin-derived keratinocytes and fibroblasts with bovine Type I collagen. (1)

Intended Use/Indications: Apligraf is indicated for use with standard therapeutic compression in the treatment of uninfected partial and/or full-thickness skin loss ulcers due to venous insufficiency of greater than 1 month duration and which have not adequately responded to conventional ulcer therapy. (2)

Apligraf is indicated for use with standard diabetic foot ulcer care for the treatment of full-thickness foot ulcers of neuropathic etiology of at least three weeks duration, which have not adequately responded to conventional ulcer therapy and extend through the dermis but without tendon, muscle, capsule or bone exposure. (2)

Contraindications: Apligraf is contraindicated for use on clinically infected wounds and in patients with known allergies to bovine collagen or hypersensitivity to the components of the shipping medium. (3, 4, 5, 8)

Warnings and Precautions: If the expiration date or product pH (6.8-7.7) is not within the acceptable range DO NOT OPEN AND DO NOT USE the product. A clinical determination of wound infection should be made based on all of the signs and symptoms of infection. (4, 5)

Adverse Events: All reported adverse events, which occurred at an incidence of greater than 1% in the clinical studies are listed in Table 1, Table 2 and Table 3. These tables list adverse events both attributed and not attributed to treatment. (6)

Maintaining Device Effectiveness: Apligraf has been processed under aseptic conditions and should be handled observing sterile technique. It should be kept in its tray on the medium in the sealed bag under controlled temperature 68°F-73°F (20°C-23°C) until ready for use. Apligraf should be placed on the wound bed within 15 minutes of opening the package. Handling before application to the wound should be minimal. If there is any question that Apligraf may be contaminated or compromised, it should not be used. Apligraf should not be used beyond the listed expiration date. (9)

Use in Specific Populations: The safety and effectiveness of Apligraf have not been established in pregnant women, acute wounds, burns and ulcers caused by pressure. (3)

Patient Counseling Information: VLU patients should be counseled regarding the importance of complying with compression therapy or other treatment, which may be prescribed in conjunction with Apligraf. DFU patients should be counseled that Apligraf is used in combination with good ulcer care including a non-weight bearing regimen and optimal metabolic control and nutrition. Once an ulcer has healed, ulcer prevention practices should be implemented including regular visits to appropriate medical providers. (3)

Treatment of Diabetes: Apligraf does not address the underlying pathophysiology of neuropathic diabetic foot ulcer. Management of the patient's diabetes should be according to standard medical practice.

How Supplied: Apligraf is supplied sealed in a heavy gauge polyethylene bag with a 10% CO2/air atmosphere and agarose nutrient medium. Each Apligraf is supplied ready for use and intended for application on a single patient. To maintain cell viability, Apligraf should be kept in the sealed bag at 68°F-73°F (20°C-23°C) until use. Apligraf is supplied as a circular disk approximately 75 mm in diameter and 0.75 mm thick. (8)

Patent Number: 5,536,656

Manufactured and distributed by: Organogenesis Inc. Canton, MA 02021

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- Evaluate how the transition will affect your EHRs or paper records. Do forms and electronic screens need to be revised?
- Review and revise, if necessary, the organization of medical records.
- Train registration personnel on how to obtain medical records from referring providers and on how to locate, print, and file national coverage decisions, local coverage determinations, and medical policies in a convenient place for everyone’s use. Establish a routine forum for communicating coverage changes to staff and patients.
- Review and revise, if necessary, policies and procedures that are affected by ICD-10-CM conversion.

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