

## The ICD-10 Transition

*What Should Labs Expect?*

By Bill Malone

Even as healthcare providers push toward a new era of electronic health records (EHRs) and information exchange, the very language used to document diseases and conditions in these records is about to shift dramatically. The Centers for Medicare and Medicaid Services (CMS) has set a deadline of October 1, 2013 for the entire healthcare industry to switch from ICD-9 to the new ICD-10 coding system that covers all medical diagnoses and inpatient procedures. Not only will the code format and numbers change, but the number of codes will grow more than five-fold. More importantly, ICD-10 offers a much greater depth of detail and description that will create ripple effects across many domains of the healthcare landscape, including reimbursement, standards of care, public health research, and fraud and abuse surveillance.

In the 2 years until the deadline, experts are urging all healthcare providers, including labs, to prepare well ahead of time or face dire consequences. As it is, labs already cope with coaxing physicians to use correct ICD-9 diagnosis codes on lab orders—a must for proper reimbursement. But with the launch of ICD-10, labs can expect confusion from physicians and possible delays from payers, a chilling combination that should motivate all stakeholders to get up to speed as soon as possible, according to Juliet Santos, MSN, CCRN, FNP-BC, senior director of business-centered systems and ICD-10 lead for the Health Information and Management Systems Society (HIMSS).

“Labs have a lot of work ahead of them. They’ll basically have to carefully guide providers to learn how to code for the lab, since physicians, nurse practitioners, and physician assistants will not have the time to learn this on their own,” Santos said. “We will still have medical necessity to answer to, so a lab can’t just give a provider a sheet that says, ‘Here are our tests, check off the ones you want.’ The new codes must be used correctly and it will fall to the labs to help make sure this happens if they want to be reimbursed for the tests.”

### **New Twist on an Old Problem**

Although the change to ICD-10 will have many new elements, one thing that will not change is the fact that labs will be completely dependent on physicians to provide accurate diagnosis codes on test orders—a unique dilemma among healthcare providers (See Box, right). Under Medicare, electronic reimbursement claims for lab tests must contain valid and specific diagnosis codes that explain the reason the tests were performed. Proper diagnosis codes are especially important in cases when Medicare establishes a National Coverage Determination (NCD) or Local Coverage Determination (LCD) that limits reimbursement to only certain situations. For example, an NCD implemented in 2003 limits glycosylated hemoglobin tests to once every 3 months for a controlled diabetic patient. In order for the lab

to receive reimbursement for a fifth glycated hemoglobin tests for this type of patient in the same year, the ordering physician would need to indicate with an appropriate diagnosis code that the patient's diabetes was not well controlled.

Unlike anatomic pathology, radiology, or other diagnostic providers, clinical labs may not code their own claims, nor can they fill in the blanks without consulting the ordering physician. This will be the single greatest challenge labs face in handling a new, more complicated universe of diagnosis codes, said Lâle White, executive chairman and CEO of XIFIN, a revenue cycle management solutions company that services the diagnostic providers market.

"Labs already spend a tremendous amount of time working with physicians on the use of ICD-9 codes for limited coverage tests, and to this day still have a fairly high percentage of diagnoses that are not coded at the highest level of specificity," she said. "Some physicians might believe it's easy to translate an ICD-9 code to an ICD-10 code—and there are cross-reference tables that are being established—but the fact of the matter is that there is so much specificity in ICD-10 that the majority of codes are not going to be translatable, thereby forcing physicians to look up the new code and use it properly. That's a big problem for the lab, where we have to rely on someone else who has no incentive to provide us with accurate coding so that we can get reimbursed." With lab claims averaging only about \$40, the huge amount of legwork it takes to fix wrong or missing codes from physicians take far more time than labs can afford, she added.

Labs will likely encounter a tricky and uncertain predicament when physicians fail to code properly, said JoAnne Glisson, senior vice president of the American Clinical Laboratory Association (ACLA). "There is undoubtedly the concern, not only that labs will have delayed payments, but that sometimes they won't get paid at all," she said. "When CMS pulls the trigger in 2013, if the physicians aren't ready, it'll be a proverbial train wreck. Payers certainly won't want to deal with claims coming in both ICD-9 and ICD-10—they'll only want to take the new codes."

ACLA and other lab groups have expressed alarm to CMS over these issues for several years, so far without any change in regulations or policy. In a 2010 letter to CMS, Glisson wrote that "the Office of the Inspector General has made it clear that clinical laboratories are expressly prohibited from rendering or suggesting diagnoses if they are not supplied by the ordering provider." The letter goes on to state that "clinical laboratories are often required to submit diagnosis data that they are prohibited from generating themselves, and that no one is obligated to provide them. We respectfully submit that this result is fundamentally unfair, and represents a misinterpretation of the applicable statute that is completely at odds with reality." While CMS has sympathized with the worries of labs and other stakeholders, there is little indication that fundamental changes will take place to make it easier on labs before the deadline, Glisson said.

### **Preparing Physicians for the Change**

To many who are directly involved in the switch, the 2013 launch seems to be just around the corner. But CMS has already delayed the ICD-10 transition after pleas from providers. In January 2009, the date got pushed back by 2 years from the original October 1, 2011 deadline. However, even with a little more time to prepare, it will be up to labs to tackle these problems and fill the gap. "It's going to be pretty intense for labs," said White. "For years, labs have been tasked by Medicare to teach physicians how to code for limited coverage tests, so with ICD-10 labs are going to have to go into a rigorous education campaign with their physicians," she said. "I'm sure there will be many visits where the lab will try to help the physician and office staff train on lab-specific ICD-10 codes. And it's going to be difficult." Once

the ICD-10 codes for NCDs and LCDs are published later this year, labs should be going full-throttle with their education campaigns, she said.

Labs will have to be very careful about how they request additional information from physicians when an ICD-10 code is missing or incorrect, advised Diana Voorhees, principal and CEO of DV & Associates, a lab consulting firm. "These kinds of requests need to be worded carefully, because labs cannot lead that physician into giving them what they want," she said. "However, there is nothing wrong with giving physicians copies of NCDs and LCDs to help them understand." In addition, due to the new level of detail possible with ICD-10, it's conceivable that Medicare could propagate even more NCDs or LCDs and with greater precision, putting greater pressure on labs to have precise and complete codes on every claim.

Helping physicians code properly now is becoming more important to ensure reimbursement from all payers, as managed care contractors and other private payers set up their own coverage policies for testing, Voorhees noted. Aetna, UnitedHealthcare, Cigna, and several other insurance companies are now limiting reimbursement independent of what Medicare is doing, and limited coverage means correct diagnosis coding is essential. "Part of this trend is due to the introduction of new molecular diagnostic tests," she said. "Overall, there are just many more tests, and yet everyone wants to limit the budget."

Inevitably, some physician coding errors will go unnoticed by labs. Added to this will be the burden on the payers themselves of coping with new software and procedures for processing ICD-10-coded claims, Santos emphasized. "A

### What's New in ICD-10

The greatly expanded ICD-10 code set represents a significant improvement over the current ICD-9 version. These codes must be used to report all healthcare diagnoses and procedures. According to the Department of Health and Human Services (HHS), ICD-10 will enable HHS to more fully support quality reporting, pay-for-performance, bio-surveillance, and other public health activities. Health plans, healthcare clearinghouses, and providers who transmit any electronic health information will be required to use ICD-10 beginning October 1, 2013. In contrast to ICD-9's 17,000 codes, ICD-10 encompasses more than 155,000 codes and can accommodate a host of new diagnoses and procedures. HHS also expects that the additional codes will help implement electronic health records because they will provide more detail in electronic transactions. This same data granularity should also boost efficiency by helping to identify specific health conditions such as Methicillin-Resistant *Staphylococcus aureus* (MRSA) and other conditions.

Prior to implementing ICD-10, providers and other organizations must also update a standard used for transmitting electronic information, called HIPAA X12 Version 5010. This standard is the vehicle for the new ICD-10 codes to be exchanged properly. The current transaction standard is the X12 version 4010A1 for eligibility, claims status, referrals, claims, and remittances. Use of the HIPAA X12 Version 5010 standard is required by federal law by January 1, 2012.

#### Code Structure Basics

- Expanding to 155,000 codes from 17,000 codes in ICD-9
- Three to seven characters compared to three to five in ICD-9
- All letters of the alphabet are used except for U

#### New Features

- Combination codes for conditions and common symptoms or manifestations
- Combination codes for poisonings and external causes
- Laterality that indicates the right or left side of the body
- More extensions for episodes of care
- Expanded codes for injury, diabetes, postoperative complications, and substance abuse
- Inclusion of trimester in obstetrics codes
- More details on ambulatory and managed care encounters
- External cause included
- Combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition
- Capability to expand the number of new codes

critical message is that all providers need to be prepared to implement a strategic plan to ensure financial sustainability for 6–12 months minimum in the high likelihood of delayed payments, as well as claims that will need to be adjusted because of errors in coding,” she said.

### **The EHR Conundrum**

One looming, unanswered question is how the push to adopt EHRs will collide with a concurrent transition to ICD-10. CMS is offering financial incentives to providers who implement EHRs beginning this year and through 2014. In 2015, so-called meaningful use of EHRs will be mandatory. In the middle of this wave comes ICD-10, and experts see both reason to worry and to be hopeful about this confluence of changes in healthcare.

“To be honest, right now it’s causing a lot of stress in the industry. Everyone wants to implement meaningful use in a hurry due to the monetary incentives attached to it, whereas ICD-10 doesn’t look quite as attractive because there’s not that immediate reward,” said Santos. “However, we can’t afford to ignore ICD-10. If providers do not plan carefully for ICD-10 at the same time that they’re implementing meaningful use of EHRs, there could be a backlash, and the money that they earn from complying with meaningful use will ultimately be lost. Failing to implement ICD-10 appropriately can send your business to a dead halt.”

Despite the fact that the ICD-10 conversion competes with EHRs for limited resources, for those providers who successfully implement EHRs, a positive synergy of the two could actually benefit labs, noted White, who also pointed out that many EHR vendors are developing coding-assistance programs as part of their EHR packages. “If done properly, the more EHRs we have in place, the easier it will be to do the ICD-10 rollout, particularly if the EHRs have either the functionality themselves for ICD-10 coding, or are integrated with some kind of electronic coding system,” she said.

Lab organizations and other stakeholders have repeatedly asked CMS to work with EHR vendors to help them incorporate coverage criteria, decision support, and other coding assistance within their products, so far with limited success, White commented. “So far CMS has not been very helpful in that realm, and so we continue as an industry to fight the battle. However, this is something I would recommend all labs to act on locally with their Medicare contractors. The payers, especially CMS, do have input on meaningful use with EMRs,” she said. “This is one of the most important things that labs can do right now, to be active personally and through their associations to put pressure on EHR vendors to deliver software that will help physicians with ICD-10 coding.”

### **Working with Vendors**

With the greatest challenges from the ICD-10 transition coming from physician offices and other entities over whom labs have little control, labs should not be overconfident in their own vendors either. In fact, labs should be asking a lot of questions, making sure that vendors for billing, the lab information system, and other services are doing all they can to be ready (See ICD-10 Readiness Assessment Questions, Online Extra box below).

White’s company, XIFIN, offers billing solutions to labs and has taken several steps to assure their customers that they’ll be ready for ICD-10. Some of their customers request not only a project plan, but want a rollout strategy of when XIFIN will be testing with payers. “They expect to see monthly updates, which we provide both in our website and monthly newsletters.

If I were a provider right now, I would be asking for that level of detail from my vendors,” White said. “A lot of labs are just assuming that vendors will take care of it for them, but I really think labs need to make sure that all of their vendors are complying at that detail level. It’s not as simple as it seems. You cannot take it for granted that this is an easy task for your vendors.”

### **Other Concerns**

Using ICD-10 will require advanced training for professional coders, but laboratorians will still want to be aware of how some of the nuances of the actual coding could affect their operations. Due to the way that ICD-10 carries more information per code, experts anticipate that some documentation requirements for claims could change. For example, currently where a payer may request a report or some kind of attachment to justify the medical necessity for a test, after the transition, many of these attachments will be taken care of through the information inherent in the ICD-10 code.

Utilization could also change, although ICD-10 is meant to be cost neutral from a reimbursement standpoint, said Santos. However, with greater specificity in codes that can better demonstrate how sick a patient really is, some have speculated that providers will be better able to show that more testing is medically necessary.

“It could be an opportunity for lab services because the ICD-10 will allow providers to code for their actual patient scenario,” she said. “Right now it’s type 1 diabetes, type 2 diabetes, complicated or uncomplicated. With ICD-10, I’ll be able to say this patient has been on insulin, has now had an amputation, has renal failure and heart disease. So with ICD-10, you’re getting a picture of a patient that is a lot sicker than the picture that we could paint before, because the coding mechanism didn’t allow us to do that.”

The new level of detail in ICD-10 will mean that everyone in healthcare will need to be exceedingly careful about how codes are used, Voorhees remarked. “Because of the great detail and specificity in ICD-10, there will have to be a full-fledged medical record that supports every one of these codes,” she

### **ICD-10 Readiness Assessment Questions for Vendors and Providers**

- Can your vendors provide written proof of compliance or their detailed planning process?
- Are hardware upgrades necessary?
- What is the process for handling ICD-9 claims after October 1, 2013?
- What are the top ICD-9 codes and the corresponding ICD-10 codes for the lab?
- Is there an implementation timeline?
- Is there an appointed ICD-10 transition team leader to monitor readiness?
- What is the most efficient and productive way to educate staff and physicians?
- Who is responsible for updating forms with new diagnosis codes?
- How will the communication be structured to gain maximum distribution?
- Does the organization participate in a research study or registry? If so, how will reporting change?
- Does the organization have worker’s compensation claims? If so, will the state’s claims administrator be ICD-10 ready?
- Who will monitor claim denials after the transition?
- Will there be reporting mechanisms in place to enable claim payment continuity?
- Will there be resources to alert providers of abnormal payment or denial activity?
- Will more staff resources be necessary to process denials?
- How will diagnosis comparison reports across 2012 and 2013 be integrated?

*Sources: North Carolina Healthcare Information and Communications Alliance, Inc. and Centers for Medicare and Medicaid Services.*

said. "For example, if you've got a patient in surgery and they develop complications post-operatively, ICD-10 codes can reflect that, and I can see legal matters and all kinds of issues coming out of this. So the coding will have to be very, very well documented before it can be reported. A lot of responsibility will go along with each code."