

FEATURES

ICD-10 and the Lab

Read on for clearly stated insight on ICD-10's impact on the clinical lab.

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Conversion Timetable

The CMS conversion milestones timetable has already passed the Phase One requirement of identification of all the impacted systems that are likely to be changed as a result of the transition to ICD-10 and the new ANSI 5010 transaction sets. These systems include laboratory information systems, billing, registration, claims submissions and scrubbing, test ordering, utilization and managed care reporting systems, not to mention data warehousing and interfaces between all of these systems.

Phase One also included vendor review to determine timetable and conversion plans. Vendor readiness is one of the biggest hurdles to achieving compliance with the new code and transaction sets. Determine early on if your current in-house or SaaS-based billing and revenue cycle management system can accommodate data format changes required for ICD-10 codes and when your vendor plans to upgrade the current system. The installation should be done early enough to test transactions through existing payors and other clearinghouses currently in use. Depending on the vendor or service contract, system upgrades may be included as part of ongoing maintenance costs.

2010 marked the beginning of Phase Two, where payors and providers are expected to perform the necessary upgrades that will enable use of the code and 5010 transaction sets. Phase Three commences in 2011, and will consist of external testing of the new transaction sets between providers and payors. The goal is completion by January 2012, followed by a go-live date of October 1, 2013, for ICD-10 conversion for diagnosis procedure code sets.



Training, Education, Documentation

When it comes to education, ICD-10 coders must increase their knowledge of anatomy and physiology in addition to knowing the most common disease processes and treatments to accurately and effectively work with the new code sets. Labs will be tasked with helping train ordering physicians on the intricacies of the code sets as they relate to medical necessity guidelines. This is a necessary step in order to provide labs with adequate information to conduct billing activities. AHIMA provides an online skills assessment tool to help determine the current ability of the individuals who need to be trained, along with a series of training tools.

Some of the edits that need to be updated in the billing system will include local and national coverage determinations as well as outpatient codes, which have a number of diagnosis related edits. Payor-specific diagnosis requirements will also need to be updated. In addition, education and support for required documentation changes in patient charts will be essential.

Finally, the National Center for Health Statistics has created the conversion mapping database known as General Equivalency Mappings (GEM) that will aid providers in creating crosswalks for bidirectional conversion of ICD-9 and ICD-10 codes. Labs and other providers will have to determine the best way to deal with bidirectional crosswalk mappings to process claims that are pre and post-ICD-10. One-to-one crosswalk equivalencies are far from certain, so claim coding automation assist technology and automated revenue cycle management error processing capabilities can help keep claims on track and minimize errors/returns.

CMS predicts a 10 percent return claim volume in the first year due to ICD-10 conversion while others predict even higher percentages of returned claims. This is on top of the additional labor costs required to retrain ordering physicians and a potential reduction in coder productivity.

For labs and other healthcare providers, how quickly you address these issues now will determine how quickly you can recover from the transition and make the most of ICD-10 both financially and clinically.

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