Nancy Maguire, ACS, PCS, FCS, HCS-D, CRT
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Featuring Nancy Maguire, ACS, PCS, FCS, HCS-D, CRT
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Featuring Elizabeth Woodcock, MBA, FACMPE, CPC
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ICD-10-CM: A Monumental Shift Ahead for Medical Providers

By now, physician practices and hospitals know a change is coming on October 1, 2014, that will dramatically impact their current way of doing business. That is the date set by the federal government for full implementation of ICD-10-CM, which will completely replace ICD-9 coding. Transitioning to ICD-10 diagnosis codes will be life-changing for medical practices and health care facilities. And it is not optional. Quite simply, providers need to be using ICD-10 coding for any claims based on dates of service from October 1, 2014, going forward—or they will not be paid.

ICD-10-CM is the new generation of diagnosis and facility procedure coding (PCS). It includes significant differences from ICD-9 that will impact how claims are documented and filed. The mere mention of ICD-10-CM diagnosis codes causes anxiety in the minds of coding professionals as well as practice administrators, and that is understandable. But health care has undergone dramatic changes before in how care is documented and paid for, such as the introduction of DRGs in the late 1980s. The best approach to ICD-10 is acceptance and a positive attitude, which should help ease each player through the process required to ensure a successful transition.

During the transition to ICD-10, it will be very important to focus on the timelines for completion and implementation. Your tasks should be undertaken one at a time, in order of priority. This white paper has been prepared to help you do just that. But you will also need focus and energy because the years leading up to 2014 will require patience and persistence, good communications and sound leadership. Taken together, this plan and your perseverance will serve as powerful tools for achieving your goals and compliance timeframes.

Why Move to ICD-10?

Although the United States has been using ICD-9 coding for 34 years, the rest of the world does not. Every country except the U.S. has been using ICD-10 coding for years. The US Department of Health and Human Services (HHS) first proposed using new code sets for reporting diagnoses and procedures on health care transactions in 2008. In addition to making us compliant with the rest of the world in the way diagnoses and procedures are reported,
The focus in 2012 should be transaction set 5010 upgrading and strategic ICD-10 planning.

ICD-10 offered other benefits as well. The new coding system offers greater detail than ICD-9. There is greater flexibility to add new codes and ICD-10 provides full code definitions. Adopting ICD-10 will bring the United States into conformity with the rest of the world and allow us all to speak the same language when describing diseases, morbidity and mortality. American data will finally be compatible with rest of the world, allowing for a single database of health trends and epidemiologic information. And theoretically, providing more specific data up front to payers should lead to less follow-up and fewer denials after claims submission. This latter point still remains to be seen—only time will tell.

Regardless of the reasons for moving to ICD-10, the transition is not optional. On January 16, 2009, the U.S. Department of Health and Human Services (HHS) released the final rule mandating that everyone covered by the Health Insurance Portability and Accountability Act (HIPAA) must implement ICD-10 for medical coding on October 1, 2014. There will be no grace period. In this white paper, we’ll discuss strategies designed to help any practices or facilities that document care make a successful move to ICD-10. For the rest of this discussion, we will be referring to those responsible for achieving a successful conversion as “Team Leaders.”

Step 1: Implement HIPAA Transaction Set 5010

Transaction sets are specially formatted text files designed to convey claim information in a manner sufficient to allow claim adjudication. The Department of Health and Human Services (HHS) issued mandatory upgrade requirements from transaction set 4010 to 5010 in January 2009 and we are now in full compliance. This was the first step in preparing for the ICD-10 coding system. The focus in 2012 should have been on implementing transaction set 5010, both upgrading and testing transaction submission with vendors, clearinghouses, payers, etc.

Transaction set 5010 is a major computer data upgrade from transaction set 4010, and will allow the transmission of electronic data to various business partners or individual payers of health claims. HIPAA transaction set 4010 cannot transmit codes required for ICD-10-CM alphanumeric code structure. The technical changes in 5010 will streamline information exchange while accommodating the ICD-10 code sets. The earlier compliance date for 5010 was purposely set in order to ensure adequate testing time for the industry prior to implementation of ICD-10.

As part of the upgrade, it will be essential to assess current computer systems. The method of communicating with CMS and other carriers must migrate from the current HIPAA 4010 file format standard to the HIPAA 5010 file format standard. The affected transactions include:

- Health care claims or equivalent encounter information for professional, institutional and dental services;
• Eligibility for a health plan (inquiry and response); referral certification and authorization;

• Health care claim status (inquiry and response); enrollment and disenrollment in a health plan;

• Health care payment and remittance advice; health care premium payments;

• Coordination of benefits

The standard for pharmacy transactions includes:

• Claims

• Eligibility requests and responses

• Referral certification and authorization

• Coordination of benefits

Health care providers, health plans and health care clearinghouses must comply with the changes to the transaction set standards. The Centers for Medicare and Medicaid Services (CMS) has a number of educational resources on its website to assist you with a smooth conversion. For more information, visit http://www.CMS.gov. From CMS home page, click “Regulations and Guidance,” and under “HIPAA Administrative Simplification,” click “Versions 5010 & D.0.”

Implementation guidelines are available for IT staff and include:

• Data elements required or conditionally required

• Definition of each data element

• Technical transaction formats for the transmission of the data

• Code sets or values that can appear in selected data elements

Define an organizational EDI strategy and determine which transactions you want to process electronically using the standard formats. Identify process changes necessary for 5010 upgrade. Reference the following website for additional information: http://www.wpc-edi.com
Develop a transition and conversion plan that includes establishing a training plan.

The detail in ICD-10 codes is greater and many codes have laterality as part of the code description, in addition to the type of encounter.

Other Issues to Address with 5010

In addition to computer upgrades, the Team Leader should develop a transition and conversion plan that addresses staff training needs. Adequate training ensures that transactions are correctly submitted, received, interpreted and responded to by the compliance enforcement deadline of January 1, 2012. A review of the entire process should be done prior to system upgrade implementation. In other words, prevention is better than damage control. When errors are identified, address them immediately and communicate with all members of the team to aid in problem solving. With any major system implementation, there are new processes that need to be followed. A transition and conversion plan with specific task assignments and corresponding accountability will help minimize problems.

There are required business changes with 5010 as well. Under 5010, a P.O. Box or lockbox can no longer be used as the provider’s billing address, unlike transaction set 4010. Practices and facilities need to be prepared to provide a physical address for the organization.

Note: For small health plans using Version 3.0, the compliance date is January 1, 2013 (Medicaid subrogation for pharmacy claims, known as NCPDP Version 3.0.). Find more information at http://aspe.hhs.gov/admnsimp/index.htm. The mandatory compliance date for ANSI version 5010 and NCPDP version D.0 (pharmacy) for all covered entities was January 1, 2011.

Step 2: Get Acquainted with ICD-10-CM Diagnosis Codes

ICD-10-CM was developed by the Centers for Disease Control and Prevention for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM, but the format of the code sets is similar with ICD-10 providing greater detail. Perhaps the greatest source of anxiety about ICD-10-CM is the rumor that there are substantial changes from ICD-9 codes. Or maybe it is the sheer increase in the number of codes: ICD-9 listed approximately 14,000 diagnosis codes, while ICD-10 includes 68,000+! The ICD-10-CM manual has 21 chapters, while ICD-9-CM codes only covered 17 chapters in the tabular list. Why the huge discrepancies? In general, the detail in ICD-10 codes is greater and many codes have laterality as part of the code description, in addition to the type of encounter. (For instance, code S61.142A denotes a puncture wound with foreign body of left thumb with damage to nail, initial encounter. The 7th digit, “A” describes an initial encounter.)
ICD-10 contains many “combination codes” that include two or more conditions/symptoms in one code descriptor. (For example, code E11.618 describes Type 2 diabetes mellitus with diabetic neuropathic arthropathy, Charcot’s joint). The ICD-10 diagnosis code set also contains two “Excludes” notes, and this is also different from ICD-9 diagnosis coding:

- **Excludes 1 note** means the condition(s) listed under that note are not coded to the referenced condition category or subcategory listed above the note.

- **Excludes 2 note** lists conditions that, if documented, could be an additional code to the main code referenced.

**Review the Draft Manual**

ICD-10 CM/PCS (International Classification of Diseases, 10th Edition, Clinical Modification/ Procedure Coding System) consists of two parts:

1. **ICD-10-CM** for diagnosis coding.

2. **ICD-10-PCS** for inpatient procedure coding by the facility.

The Official Guidelines are found in the beginning of the draft manual and should be read and understood before attempting to assign codes from the Tabular list. Chapters have all been re-grouped into “blocks” appearing at the beginning of each chapter. For instance, ICD-9-CM codes beginning with a “V” are grouped under the classification “Factors Influencing Health Status and Contact with Health Services.” ICD-10-CM codes listed under this same classification now begin with Z00 through Z99, chapter 21, broken down into related subclassification codes or blocks. Structural changes within the ICD-10-CM book include the deletion of hypertension table, as well as the terms “benign”, “malignant” or “unspecified” hypertension (ICD-9 codes 401.0, 401.1, 401.9). The ICD-10 code for essential hypertension is I10. The ICD-10 manual is still divided into an alphabetic index and a tabular listing and still requires proper look up in the index and cross-referencing to the tabular list. The index in ICD-10-CM is expanded but the formatting is similar to the ICD-9 index, only expanded.

**Use Both the Index and Tabular List**

It is essential to use both the Index and Tabular list when locating and assigning a code. The Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular list. A dash (-) at the end of an Index entry indicates that additional characters are required. Even if a dash is not included at the Index entry, it is necessary to refer to the Tabular list to verify that no 7th character is required (Official Guideline).
Traditional conventions are still applicable. Brackets still enclose synonyms, parentheses still depict nonessential modifiers, and NEC and NOS notations still exist. There are still “inclusion” notes, sequencing notations (code first / use additional), and “see” or “see also” notes. Acute conditions are still coded before chronic conditions and general coding rules still apply.

Etiology/manifestation sequencing rules apply in many cases, especially if you see “in diseases classified elsewhere” in a code descriptor. Wherever such a combination exists, there is a “use additional code” note at the etiology code, and a “code first” note at the manifestation code. These instructional notes indicate the proper sequencing order of the codes, etiology followed by manifestation. In most cases the manifestation codes will have in the code title, “in diseases classified elsewhere.” Codes with this title are a component of the etiology/manifestation convention. The code title indicates that it is a manifestation code of an underlying condition.

The use of a “placeholder” is a new concept not seen in ICD-9-CM diagnosis coding. The ICD-10-CM utilizes a placeholder character “X”. The “X” is used as a 4th, 5th, or 6th character for certain category codes requiring a 7th character, but missing a 4th, 5th, and/or 6th character. Some codes already have the “x” placeholder to allow for future expansion. Where a placeholder exists, the X must be used in order for the code to be considered a valid code. Example, code O33.5- describes “Maternal care for disproportion due to unusually large fetus”, this subcategory requires a 7th digit to specify single gestation or specific fetus, if multiple gestation. If documentation confirms a single gestation, the 7th character is “0”. This code is invalid unless it contains 7 characters. In this case placeholder “x” is placed in the 5th and 6th digit place followed by the 7th character “0”. The full code assignment would be O33.5xx0.

ICD-10-CM diagnosis coding will shake up the coding profession because it is a major change in the way business is done, and has been done for 30 years. Take heart, though—it is a learning process and given adequate time to train (start in January 2013) and absorb the changes, we will become as familiar with the alphanumeric ICD-10 codes as we are with ICD-9 diagnosis codes.

**Step 3: Assess What the New Codes Mean for Your Practice**

While the changes with ICD-10 coding may seem daunting, the reality is that NO practice will ever be working with all 68,000 codes. Let this reality focus your transition to ICD-10. Once you have become somewhat familiar with the new diagnosis code set, run a report on the diagnosis codes billed 80% of the time in your practice. This important exercise will help you hone in on the scope of changes that will require your attention. A key tool for this will be General Equivalence Mappings, or GEMs.
GEMs were developed as a tool to assist with the conversion of ICD-9-CM codes to ICD-10 codes or back again when transferring large data sets. GEMs are also referred to as “crosswalks” since they provide important information linking codes of one system with codes in the other system. GEMs were developed over a period of three years by CMS and CDC, with input from both the American Hospital Association and the American Health Information Management Association. Using GEMs, you can crosswalk your current codes to ICD-10 codes and see the differences in coding structure, documentation needs, education and training. Consider changes to existing processes including clinical documentation, encounter forms, and quality and public health reporting. For instance, superbills may need a face-lift, or you may decide not to put ICD-10 diagnosis codes on the charge document unless it is a 3 digit code only. The GEMS are not used to code diagnostic statements from a medical record. The coder must refer to the Index and Tabular list for accurate code assignment.

ICD-10 codes are much more specific than ICD-9 codes and this will impact payers who may modify terms of contracts, payment schedules, or reimbursement. The business office of a practice or facility must identify potential changes to work flow and business processes. Other concerns are payer contracts, particularly dealing with coverage determinations, and “increased documentation costs.” Pre-authorizations and treatment plans may require additional diagnosis documentation to specify the detail of the patient’s condition(s). Assess whether the documentation currently in your medical records system will support the level of specificity necessary for ICD-10-CM.

Special attention should also be given to the current skill sets of those most involved with coding and billing. Because of the specificity of the new coding system, staff may need additional training in anatomy or biology. Transitioning to ICD-10 will almost be like learning a new language. If coding and billing employees do not know the correct terminology, the practice simply won’t be reimbursed for care. Team leaders should conduct a comprehensive gap analysis to determine what training needs should be addressed. This transition will be time-intensive and will involve costs and additional resources. It will impact your entire practice and will require patience and persistence.

**Documentation: the Silent Witness**

Perhaps the single biggest issue to be addressed in transitioning to CDM-10 will be the increased need for documentation. It is a fact that the ICD-10 diagnosis codes, as well as the procedural coding system (PCS), will require an increase in physician documentation. It is also quite probable that this increase in documentation will change patient scheduling, resulting in fewer patients seen on a daily basis (for example, 3 less patients per day). The old order for documentation standards will no longer be enough after October 1, 2014. The new order requires greater detail and will be a permanent change.
in documentation habits. Teamwork, or lack thereof, between the clinical staff and the coding professional will make or break the smooth transition to ICD-10 compliance. The brutal fact is that many physicians do not document for specificity with current ICD-9-CM codes and this will make implementation of ICD-10 coding a frustrating experience. Improved physician medical documentation is critical to reimbursement and data collection.

The coding professional cannot diagnose, nor can she assume a diagnosis. The physician and non-physician clinicians must specifically document the presenting symptoms or chronic and acute conditions, in detail. ICD-10-CM diagnosis codes have laterality in many code descriptors and many require a 7th Character Extension (A, D, S) Initial, Subsequent, Sequela, to identify the type of encounter. It is reassuring to realize that the rules, conventions, and guidelines in ICD-10 are very similar to what is currently in ICD-9, with only a few changes. Also on the plus side is an increase in “combination codes” and this means one code would be assigned in place of 2 or 3 separate codes required in the ICD-9-CM system (for example, I25.110 ASHD of native coronary artery with unstable angina required 414.01 and 411.1 in ICD-9).

Without question, the most critical area of impact of ICD-10 for physicians will be on documentation. Physicians must understand the expanded code descriptors, and these should be mirrored in their medical record dictation/documentation. Education should focus on diagnoses frequently assigned and then cross-walked to ICD-10 codes. Identify current and future documentation challenges and train accordingly. The new codes are alphanumeric and could contain seven characters (injuries, coma, OB, external causes), and they are organized differently. For example, injuries are grouped by anatomical site rather than injury category (S63.293A, Dislocation of distal interphalangeal joint of left middle finger, initial encounter).

The Center for Medicare and Medicaid Services (CMS) feels the increased specificity will make it easier to assign codes correctly, which should result in fewer errors, fewer unpaid claims and therefore fewer requests to resubmit claims with supporting documentation. Time alone will show if this assumption plays out as anticipated. It won’t be easy putting ICD-9 codes to rest. Physicians use (and frequently struggle with) these codes on a daily basis, but they are familiar with the three-five digit codes; change may not be their choice, but it will happen.

Complete and detailed documentation helps physicians organize their observations and examination, justify their treatment plan, support the diagnoses, and document patients’ progress and outcomes. The medical record is a vehicle of communication for providers to evaluate, plan, and monitor patients’ care and treatment. Documentation also supports severity of illness, length of hospital stay, and risk of morbidity/mortality data.

Physicians must understand the coding methodology not only with ICD-9 codes, but during the conversion to ICD-10 codes. Proper documentation does improve quality issues and impacts the physician’s profile for case-
Documentation errors and omissions clearly put physicians at risk for denials and audit liability.

mix decisions. In the outpatient setting, diagnosis code(s) regulate the level of service provided. Improving physician documentation ensures that the patient’s clinical course is clearly recorded. Physicians should be involved in the transition process and communication between team members should be frequent and positive. Gripe sessions will go nowhere and will sabotage the road to compliance.

**Medicare has Documentation Guidelines**

Medicare has documentation guidelines for the Evaluation and Management codes and these should be reviewed by all providers ([https://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp](https://www.cms.gov/MLNEdWebGuide/25_EMDOC.asp)). Documentation errors and omissions clearly put hospitals and physicians at risk for denials and audit liability. Does your physician clearly explain the impact of co-morbid conditions and complications in the medical record? If diagnostic tests are ordered, does the medical record document “why” or “because”? Answers to these questions will lead to a diagnosis code assignment(s). The diagnosis should link to the service provided (medical necessity).

Physicians should document the patient's severity of illness, including: severity of the signs and symptoms exhibited by the patient; the medical predictability of something adverse happening to the patient; the need for diagnostic studies; and the availability of diagnostic procedures at the time when and at the location where the patient presents. The documentation of medical necessity needs to be legible, complete (including checklists and templates) and consistent with the presenting problem(s) or condition(s).

The information written and maintained in patient health records, once it is collected and aggregated, is used by payers, clinicians, health system planners, researchers, and decision-makers as the basis for important decisions related to health care. The medical record is the silent witness to support services rendered and reimbursed. Good physician documentation ensures that a better quality of data will be available on which to base critical health care decisions.

**Step 4: Create a Blueprint for Implementation**

Once the Team Leader has become familiar with the ICD-10 codes that will be utilized most and has a better idea of their impact on the practice, it is time to create the blueprint for implementation. At this point, it isn’t too soon for the Team Leader to establish an implementation team to help guide the transition.

**Put together a well-rounded transition team** made up of representatives from management, coding, clinical, finance and information technology. The team should have a working knowledge of ICD-10 and how it differs from ICD-9, as well as the expected short- and long-term financial, personnel, and
time impact of the transition. Failure to successfully convert will result in failed claims and halted cash flow. All Medicare billing for discharges on or after Oct. 1, 2014 will be ICD-10 based. Until Sept. 30, 2014 encounters and discharges will be ICD-9 based. There will, however, be a period where staff may be working with both sets of codes—the date of service is the determinant. There are bound to be reimbursement delays when these codes are first transmitted; the budget should allow for this delay.

Include team members when discussing key questions for the plan’s development:

• What changes need to be made in your area?
• What resources do you have?
• And, what resources are needed?
• How will success be measured?

Develop a plan of action based on team input and keep the focus on the compliance timelines. Create deadlines with responsibilities and accountability. Link the right person to each task and do not lose sight of the goal. Determine the critical path necessary but allow some slack for unforeseen events. This process will probably take longer than you think---take that into account.

Assess the training needs of anyone who will be involved—even peripherally—in documenting services provided. Staff members who will require training in preparation of ICD-10 codes include coding staff, clinical staff, physicians, billers, managers and information systems. Because ICD-10 is more granular and detailed, even experienced professional coders and billing personnel will require focused training to become proficient with the new diagnostic codes and documentation requirements. Because of the higher level of specificity required under ICD-10, it is important to assess your current level of clinical documentation. This can be accomplished by evaluating random samples of medical records to identify areas where documentation is lacking. Assess the diagnoses frequently used in your practice that will require a higher level of detail. Identify areas of documentation weakness and address the deficiencies prior to the transition deadline. The documentation issues should be a focus in physician and staff education.

Audits of current physician documentation will aid in identifying documentation deficiencies and are an excellent methodology for physician education. “Show me, don’t tell me” is often heard from physicians when discussing documentation or code specificity. This is where the CMS websites, WHO (World Health Organization), and other government sites contribute to reliable sources of information. Take advantage of workshops and webcasts. Involve the physicians in the audit process; identify patient
Enlist the help of a physician “champion” to assist in physician communication and education.

Your action plan should establish timelines for training and a plan to report progress and monitoring.

records already coded with ICD-9 diagnosis codes and crosswalk to ICD-10 codes.

As previously noted, ICD-10 will require the focused involvement of physicians and non-clinical staff. Physician documentation must become more specific to accommodate ICD-10 coding. If possible, enlist the help of a physician “champion” to assist in physician communication and education. Schedule several training sessions, if possible, to familiarize physicians with ICD-10 coding requirements. If electronic documentation and coding systems are not used, physicians and nurses will need training on capturing the appropriate level of information to support coding under ICD-10.

When communicating with physicians and staff, make sure your message is clear and understood. Mutual respect is essential and egos are unacceptable.

Develop a budget for accomplishing the transition. Direct costs may include hardware or software upgrades, staff training—likely to comprise the biggest outlay of dollars—and changes to forms or in-office processes. This also requires estimating the financial impact that short-term disruptions in cash flow will have immediately after October 1, 2014. And if current predictions come true, there may be a permanent dip in provider productivity if they are seeing three less patients a day due to the demands of increased documentation. The overall cost of the transition will depend on practice size and the technology upgrades needed, as well as training and resource expenses.

Develop a communications plan that keeps everyone within the practice or facility abreast of the progress toward implementing ICD-10. Remember this is a team effort. Team leaders will need buy-in across all levels of the organization, as well as to convey an understanding of the compliance deadlines and role each staff member plays in meeting the expectations of the practice come October 1, 2014. Use employee newsletters, break room flyers, staff meetings, paycheck stuffers and your Intranet to keep everyone “in the loop” on the transition’s progress and key milestone dates.

Upon completion of the planning phase, organizations should have a strategic blueprint that details all the steps necessary—with timelines and accountabilities—to achieve a successful transition. Everyone must be on the same page and a Mission statement would help this goal. Describe what you’d like to accomplish and solicit ideas towards that end. In this way everyone has a voice and clear direction. This change will occur and everyone must focus on the practice blueprint and adhere to set schedules.
Step 5: Stick to the Timeline for the Transition

January/February 2012  With the compliance and enforcement deadlines for 5010, every entity that sends or receives electronic transactions such as claims submissions, eligibility inquiries, claims acknowledgments and reports should monitor these transactions closely and make any changes necessary to ensure success.

It is also not too late to assemble the ICD-10 transition team. Ask the team to research how the transition to ICD-10 will impact their respective areas and bring those findings to planning sessions beginning in early 2012.

Early 2012 – Develop a plan of action, communications plan and budget
Conduct a gap analysis of training needs, since education will be one of the biggest areas of focus for success. It will also be one of the costliest aspects of the transition.

Late 2012/Early 2013 – Begin education and training – It is expected that learning to use ICD-10 will require a 6-9 month timeline. There are many training opportunities and materials available through professional associations, online courses, webinars, the CMS web site, and onsite training by outside consultants. By now organizations should also have decided on the structure of their training. For instance, will they bring someone in who can conduct sessions for all staff, or will they train an internal trainer? Will they send staff off-site to training classes? The solution will be unique to each individual practice or facility. Training tools, such as the draft manual for ICD-10 and the CMS web sites to monitor progress, are essential pieces of the education endeavor.

Focused education should begin in December 2012 or January 2013. Coding staff may require two days to one week based on their current skill level and practice needs. Physicians may require 8-10 hours to gain an understanding of the code detail required. Training should be directed at the individual practice case-mix to capture the most frequently billed diagnoses.

Make staff training a priority. Foster respectful dialogue and resolve conflicts as they arise. One suggested exercise is coding case examples in a group setting that fosters a dialogue on the code’s accuracy. A group discussion with everyone’s input and suggested corrections will be invaluable to accurately coding assignments prior to going live. The educator must be knowledgeable on ICD-10 codes and this may mean using an external consultant. Another option is to designate one person to become the organization’s ICD-10 expert.

October 1, 2014 – On this date, there is no going back. Any care rendered to patients from this day forward must be submitted using ICD-10. There is no grace period for “falling back” on ICD-9 codes.
Ongoing:

**Progress meetings** – Your action plan should establish timelines for training and a plan to regularly report on progress. Hold regular meetings to monitor the progress of each initiative, flag any problems and brainstorm solutions. Each meeting should include discussion on upcoming deadlines for completion.

**Internal communications** – It is never too soon to start conveying the immense undertaking this transition presents. Begin now to engage employees and earn their buy-in—this is a long-term process.

**Communicate with Payors, Partners, Vendors** – Remember, this transition affects everyone who is involved in delivering or paying for care. Providers, payers and trading partners should communicate about their transition preparations. Not only is it important for you to make sure that you can count on them during the transition, but they are a great resource to provide details about what you need to do to comply with Version 5010 standards and ICD-10. Follow the progress on the CMS (Centers for Medicare and Medicaid Services) web site. Education is essential because this will foster clearer understanding of HIPAA 4010 transactions and the 5010 upgrade. The transition also includes business and regulatory processes, clinical data needs, and technical and front-end process changes. Payer websites can be a great source of information and provide vendor-specific information you may need to create your new in-office processes.

**ICD-10-CM in Conclusion: You CAN Succeed With This Transition**

Transitioning to ICD-10 is a significant change and should not be taken lightly. Doing the right things at the right time is crucial, and that means arming yourself with the knowledge you need that will help your practice manage the changeover. Advanced preparation is the key to understanding and implementation of the ICD-10 codes. Do the due diligence. Then identify the actions, priorities, responsible parties and deadlines for the various tasks necessary, and require accountability. With a well thought-out plan and dedicated transition team, you WILL succeed in the transition to ICD-10.
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Clearinghouse Services
Integrated electronic claims, electronic remittance advice and insurance eligibility services.

My practice’s cash flow has improved by 90%!

“My cash flow has improved by 90%. We’re now receiving insurance payments within two to three weeks and there have been almost no rejected claims that have been outstanding for more than one month. Kareo will positively change your billing service or your medical practice.”

Christine Rykiel
LCSW Practice Owner, Mental Health
Baltimore, MD

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