Recently I was addressing a group of healthcare dilettantes to discuss the impending transition from ICD-9 to ICD-10 and the various processes, staff resources and impact areas expected to be affected by the changeover within the physician practice setting. One person rather abruptly raised his hand and emphatically blurted "Can you speak in English, please! This is all Greek to us!"

Ok, now I understood. Even though I had been immersed in ICD-10 for more than a year, I needed to remember that many folks are just getting started down the path to transition: a circuitous path impacting not only clinical and administrative talent directly involved in the day-to-day activities of providing services, but numerous other peripheral healthcare staff with skill sets in information technology/information systems (IT/IS), finance and accounting, staff augmentation, and sales.

So I took a step back in my presentation and started from the beginning, describing how ICD-9-CM diagnosis codes currently are generated, applied and reported by the typical physician practice, then dovetailing that information into what's anticipated for ICD-10-CM. Here's a synopsis of that "journey."

Background

ICD-9-CM codes, representing the clinical reason(s) for an office visit, usually are generated by a face-to-face visit with a healthcare provider. The migration of the patient through the physician practice begins at the check-in desk and ends with his or her departure from the office, although the visit data continues to be handled, assessed, processed and ultimately reported for reimbursement well beyond that point. There's even an "afterlife" for this data if the initial claim is not reimbursed or is paid at a suboptimal rate due to denial, insufficient or incorrect information, or fee schedule error.

Presently, the basic office systems and internal resources involved in the generation and application of ICD-9-CM diagnosis codes are:

- Practice management IT systems, including scheduling modules and electronic medical records, or EMRs (or manual systems for non-computerized offices);
- Staff resources: providers, coders, billers, collections staff, data entry resources, etc.; and

- Coding/billing IT systems for claims generation (or manual tools for non-computerized offices).

With the advent of ICD-10-CM, it is important to consider that numerous provider offices are not yet computerized. While some might have electronic laboratory ordering and lab results retrieval capabilities, this doesn't necessarily mean the office is fully or even partially computerized. And even at this stage of modernization, with government initiatives such as the Electronic Health Record Incentive Program (more commonly referred to as the "meaningful use" program because of the criteria required to obtain available federal subsidies), there are multitudes of medical practices not yet transitioned to EMRs.

On a positive note, many partially computerized practices are leaping into EMR with "meaningful use" assistance and are melding disparate practice systems or e-modules into one fluid system able to handle practice management functions (scheduling, superbill generation, patient demographics, etc.), EMR functions and coding/billing functions.

Following ICD-9-CM Code Generation for the Typical Office Visit

Step 1 - Check-in/Registration:

A patient presents for an office visit. In preparation for the visit, the practice receptionist generates an encounter form commonly referred to as a superbill or a fee ticket. This is the

primary charge capture tool utilized by most physician offices. For practices on EMR, this "document" might remain in an electronic format, accessed on monitors or touch screens positioned at various service points within the practice, or by using hand-held palm pilots (or it simply might be screen-printed to paper for facile use). Using the practice management system, the superbills are generated from each provider's daily schedule of patients.

When billing or EMR modules are involved in generating the superbills, the data used for these documents may be dovetailed with data entry from the patient's prior visits, specifically demographic and clinical information already embedded in the coding/billing system. One way or another, even if done by hand, a superbill is generated. The majority of IT systems currently allow superbills to be generated with the most recent set of ICD-9-CM codes associated with a particular patient. ICD-10-CM codes, when implemented, likewise initially will be accessed at this point.

Step 2 - The Provider (SOAP) Encounter:

While in the treatment or exam room, the patient will be asked for subjective (S) information about his or her condition (information that might be coded), will be objectively (O) evaluated and provided an overall assessment (A) (which, when documented, will be punctuated by diagnostic statements that will be coded), and will be provided a care plan (P) or treatment regimen. During this process, the patient might undergo various testing and studies (glucometry, hemoccult, EKG, CXR, etc.) All of this activity is substantiated by confirmed diagnoses abstracted from the diagnostic statement(s) or by documented signs and symptoms gleaned from the chief complaint and subjective data - for example, the diagnostic statement "rule out appendicitis" in a patient with abdominal pain and vomiting will be coded using ICD-9-CM codes representing the abdominal pain and emesis only, not suspected appendicitis.

This data is required to substantiate the medical necessity of the patient encounter as well as any laboratory work or other tests or studies performed or ordered. The information subsequently is entered into the EMR superbill or onto a paper superbill. In the ICD-10 milieu, all of this activity likewise will occur.

Step 3 - Checkout, Claims Generation and A/R Management:

At this point the patient officially signs out of the office, typically accompanied to the checkout point by the superbill. The receptionist reviews the encounter data, adds up the various services and collects the patient's co-pay, co-insurance and/or deductible amounts.

The patient departs and the receptionist, along with performing other clerical activities, initiates a quick final scan of the encircled or entered ICD-9-CM codes in or on the superbill. Internal tools such as ICD-9-CM "cheat-sheets" complete with the practice's most frequently used codes may be accessed at this juncture - often these tools likewise are used in the coding/billing department, as well as by collections staff.

Then questions, comments or concerns about superbill entries, together with the MRs, are routed back to the providers' assistants or scribes (or they are sent directly to the providers themselves for clarification). If a paper MR and hard-copy superbill are used, the finalized superbill is separated from the MR, which may be filed or sent to transcription, and the superbill then is sent to the coding/billing department. If the practice utilizes a professional billing company, the batched superbills from the day's patients will be sent to the billing company for processing.

In the coding/billing area assigned personnel perform another check of the superbill to ensure that all appropriate ICD-9-CM codes are documented for services performed (a task referred to as code linkage), and also enter the visit data into the billing system.

When coders are involved in the visit processing work, a comparison of the service and diagnosis codes against the actual MR documentation or EMR screens often is performed; just as often, however, no MR reference or final comparison with the chart notes is done at all. The superbill, then, may stand as the sole document utilized as the vehicle for accurate and appropriate coding and billing for the patient encounter.

At this juncture the ICD-9-CM code "libraries" or IT data files are accessed during input of the encounter data into the billing system by coding/billing personnel or data entry staff. Those data files currently hold the ICD-9-CM code library, but soon enough they will house ICD-10-CM data. Furthermore, there probably will be an estimated three to six months of overlap time, during which practice coders/billers may utilize ICD-9-CM and ICD-10-CM data simultaneously, reporting both sets of information to the various payers with which the practice participates.

Once the patient's encounter data is entered into the billing system - in many cases after a claims scrubber program has been run - a CMS-1500 claim form will be generated to submit to the patient's insurer (either Medicare, Medicaid, BCBS, Aetna, HMO, etc.). This can be a weekly duty, but claim generation often is performed in busy medical offices several times a week.

For practices utilizing third parties for their billing functions, i.e., claims clearinghouses, the e-files containing the pre-submission billing data are transmitted to the clearinghouses for final formatting and claims scrubbing. The claims then officially are reported to the various payers.

After the patient's reimbursement is received from the payer together with remittance advice or explanation of benefits, a review is performed to ensure that appropriate reimbursement has been received. For denied, underpaid or suspended claims (or for additional information to substantiate medical necessity), ICD-9-CM code data may be at issue.

To resolve these issues, personnel assigned to accounts receivable (A/R) management and claims follow-up are usually responsible for possessing knowledge of ICD-9-CM coding, experience in evaluating and correcting initial claims errors, and expertise in constructing correspondence with third-party payers, including federal and state payers.

These staffers will access the patient accounts, verify disparate parts of the patient encounters in question, make claims corrections if necessary, generate updated claims and resubmit the CMS-1500 claim forms or remit necessary additional MR documentation to get the services paid appropriately.

Summary

Providers and various clinical and administrative personnel working in physician practices will be affected by the transition from ICD-9-CM to ICD-10-CM, necessitating education and training (E&T), updated internal tools, and access to updated IT systems. In this short article, we have provided a high-level overview of these personnel and their internal responsibilities. In operational order, again, they are:

Medical Office Staff

Touchpoints

ICD-10-CM Impact

Receptionists

Check-in and Checkout

-IT systems

-Internal tools

-ICD-10-CM E&T (functional)

Providers

Treatment areas

-IT systems

-Internal tools

-ICD-10-CM E&T (provider-level)

Ancillary Clinical Staff

-Treatment areas

-Laboratories

-Nurses/Scribes Stations

Transcription

-IT systems

-Internal tools

-ICD-10-CM E&T (provider-level or functional)

Coding/Billing Staff

Coding/Billing Department

-IT systems

-Internal tools

-ICD-10-CM E&T (in-depth)

Coding/Billing Staff

Third-Party Interface

IT systems

A/R Mgmt. & Collections

Managers and Collections

-IT systems

-ICD-10-CM E&T (in-depth)

IT/IS Interface

Managers

IT systems

Touchpoints in the physician's office anticipated to be affected by the transition to ICD-10-CM will vary, but there are sure predictions that can be made: at the very least, the above listed personnel will need to have knowledge of ICD-10-CM coding to some degree. Some staff will need in-depth knowledge of ICD-10-CM codes while others only will need operational familiarity with the new code system.

Various internal tools and office systems (IT and manual) will require revision and updating in the change from ICD-9-CM to ICD-10-CM. Office efficiency in administrative operations, clinical operations, coding/billing functions and A/R management likewise will be affected until all parties are proficient in ICD-10. IT systems - including scheduling and demographic modules, coding/billing systems, third-party and clearinghouse interface(s), and practice EMR systems - will require new data files and ICD-10 functionality, updated linking (especially if ICD-9 and ICD-10 systems will be run concurrently for a time), staff training on the revised systems, and the ability to generate claims in the 5010 format versus the current 4010 format. All of these matters should be considered when contemplating what touchpoints ICD-10-CM will impact in the physician office, and to what degree.

About the Author

Michael G. Calahan, PA, MBA, is the director of physician services at KForce Healthcare, Inc. Michael has more than 25 years of experience in health care, beginning as a physician assistant with the USN. He has served as an administrator for several physician practices and has enjoyed a varied career in healthcare consulting, being affiliated with Ingenix, CGI, Navigant, PWC and Parente-Randolph. He has authored numerous industry publications and articles in physician, IP/OP/ASC, DMEPOS, ESRD, HHA, ambulance, HIPAA and in Medicare Parts C & D for Medicare Advantage.

Contact the Author

mcalahan@kforce.com

To comment on this article please go to editor@icd10monitor.com