3M Health Information Systems

ICD10 Implementation from Abroad-

3M Belgium, September 24 2013

Marc Berlinguet, MD, MPH, FRCPC
International Manager, Clinical and Economic Research, IBU

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Agenda

Title, Subhead

- Introduction
- USA
- Spain&Portugal
- Canada
- Concluding notes

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USA Implementation

CMS is Moving Steadily Forward with ICD-10 Implementation

- "HHS has no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required to implement ICD-10-CM/PCS on October 1, 2014"

  CMS Website

- ICD-9 Obituary

  "The final updates to ICD-9-CM codes will take effect on October 1, 2013…this final ICD-9-CM code update is a historic occasion"

  CMS Website

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Congressional Bills Opposing ICD-10 Implication

- Cutting Costly Codes Act of 2013

"To prohibit the Secretary of Health and Human Services replacing ICD-9 with ICD-10 in implementing the HIPPA code set of standards"

  - H.R. 1701 introduced by Mr. Poe (TX) on April 24, 2013
    - Co-sponsors: 20
  - S.972 introduced by Mr. Coburn (OK) on May 16, 2013
    - Co-sponsors: Paul (KY), Barrasso (WY), Boozman (AR), Sessions (AL)
    - Mr. Colburn's attempt to make S.972 a non-germane amendment to the farm bill failed

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And what about SNOMED-CT?

- SNOMED-CT is a nomenclature: its has a collection of concepts linked by coding conventions
- ICD10-CM is a classification, namely is EXHAUSTIVE and MUTUALLY E XCLUSIVE
- SNOMED-CT and ICD-10-CM are complementary
- UMLS (USA) provides a map for 15,613 SNOMED CT concepts (frequently used in problem lists) to ICD10CM codes to SNOMED-CT.

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And what about ICD-11?

- WHO initial motto was ICD-11 for 2011
- Recent ICD-11 goal dropped in 2012: link all ICD11 concepts in ontological relationships (semantic networks for aetiologies, manifestations, even symptoms)
- Current reduced goal: develop relationships with a subset of SNOMED-CT (starting with UMLS map) and have split mortality and morbidity sub-classifications
- Lead developer recently hinted that ICD-11 might available around 2020!

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Opposition to ICD-10CM is Primarily from the AMA

- AMA House of Delegates has voted repeatedly to vigorously oppose adoption of ICD-10CM
- AMA commissioned a study to evaluate feasibility of skipping ICD-10 and waiting for ICD-11
  - Study concluded ICD-11 would be more disruptive for physicians
  - House of delegates rejected the study
- Reasons for AMA opposition are unclear
  - Unfunded mandate
  - Big brother
  - Holding back time

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Myth : The number of codes used by physicians will increase from 18,445 to 141,752.

- This is the ICD-10CM myth most often repeated.
- But since physicians never have to use the procedure portion of ICD-10CM , this myth misrepresents the facts. Under ICD-10CM, physicians will have to deal with **69,832 ICD-10CM diagnosis codes instead of 14,567 ICD-9CM diagnosis codes.**
- While this represents a substantial increase in the number of codes, the impact of that increase is **highly dependent on the volume of codes that are relevant to a physician's clinical specialty and the type of additional clinical detail that is required by ICD-10CM.**

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ICD-10CM Criticism:There is nearly a five-fold increase in the number of diagnoses codes making ICD-10CM overly complex and difficult to use

- **Laterality** specify the side of the body part increases the number of ICD-10 CM codes by 25,626, or **46 percent of the total increase** in the number of codes.

- The second cause of the increase in the number of diagnosis codes is in the **injury and poisoning section** of ICD-10CM: 39,869 injury and poisoning codes in ICD-10CM compared to 2,587 in ICD-9CM. The right/left distinction is one reason for the increase, but the larger reason for the increase is due to the ICD-10CM requirement to specify the **stage of treatment of the injury (initial treatment of the injury, follow-up treatment of the injury or treatment of the long-term effects of the injury).**

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Additional anatomic specificity constituting much of the remaining increase in ICD10-CM diagnoses

- For example**, in ICD-9CM there are 892 codes in the musculoskeletal system, and in ICD-10CM there are 6,339 codes**.
- there are **23 ICD-10CM diagnosis codes for rheumatoid arthritis**, each one specifying the joint involved and whether it affects the right or left side. There **is one ICD-9CM rheumatoid arthritis code**, and it contains no anatomic site detail.

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ICD-9CM code 996.1 (Mechanical complication of other vascular device, implant and graft)

- contains no information on the type of surgical complication (i.e., breakdown, displacement, leakage, etc.) and no information on the type of device, implant, or graft (aortic graft, dialysis catheter, arteriovenous shunt, counter pulsation balloon, etc.).
- In ICD-10CM, full detail on the type of surgical complication and device, implant, or graft is provided. This results in this one ICD-9CM code being expanded into **156 ICD-10CM codes**.

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ICD10CM-Procedures Classification System (PCS)

- ICD-10CM procedures are structured as tables in which key attributes of the procedure:
  - anatomic site
  - approach,
  - device
  - root procedure, etc.
- are combined together to create the code.
- The ICD-10CM procedures contain only 3,121 unique terms that are used to form the 71,920 procedure codes.

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ICD10CM Procedures Classification System (PCS)

- Learning ICD-10CM procedure coding is straightforward and involves becoming familiar with the 3,121 terms, most of which are either an **anatomic site** or a **device**.

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ICD10-Procedures Classification System (PCS)

- For example, consider ICD-9CM procedure code **39.31 (suture of an artery)**.
- This code contains no information on which artery (abdominal aorta, radial artery, etc.) was sutured or the approach used to perform the procedure.
- In ICD-10CM, there is full specification of anatomic and approach detail so that this particular ICD-9CM procedure code becomes **195 codes in ICD-10CM**.

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ICD-10 Criticisms

- The 470,000 words in Webster's unabridged dictionary does not make the English language more difficult to use
- Strangely out of touch with today's digital world
  - Enter the phrase "ICD-10" on Google and there are 13 million matches
  - There is a free ICD-10 iphone app to look up ICD-10 codes

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ICD-10 Criticisms

- Because there are ICD-10 diagnosis codes that will rarely if ever be used, the system is riddled with unnecessary detail
  - The often repeated external cause codes for being bitten by an alligator or crashing in to a lamp post
  - Except for external cause codes that deal with medical interventions (operation on wrong body part) virtually no payer requires the external cause codes to be reported (with the possible exception of worker's comp claims)
  - **Arguing against ICD-10** because it contains **some codes that are virtually never used** is **like arguing against English** because it contains the word ***floccinaucinhilipilification***

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ICD-10CM Criticisms

- ICD-10 CM was developed by bureaucrats who are out of touch with the real world
  - Same process used to develop and maintain ICD-9CM was used for ICD-10CM
  - Extensive public input
  - ICD-10 CM represents a consensus of healthcare stakeholders on the level of detail to be included in a diagnosis coding system

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So what about : floccinaucinhilipilification?

- ***Origin*** 1735–45
- from *Latin:*
- *floccī + naucī + nihilī + pilī*
- Meaning: all meaning "of little or no value, trifling" + -fication
- *Worthless* or *trivial may apply to counter arguments regarding usage of ICD10CM diagnoses*

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Payment Challenges with ICD-10 Conversions

- Since there will be no ICD-10 coded data available prior to October, 2014, the initial ICD-10 version of groupers (MS-DRGs, APR DRGs) must replicate the ICD-9 version of the grouper
  - *Replication*: to the extent possible, the group assignment will be the same whether a claim is coded in ICD-9 and grouped with the ICD-9 grouper or coded in ICD-10 and grouped with the ICD-10 grouper

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Payment Challenges with ICD-10CM Conversions

- In October of 2014, there will be minimal payment redistribution across hospitals due to ICD-10CM
  - MS-DRGs: 1.0 percent of claims will change MS-DRG assignment having a net 0.004 percent payment reduction
  - APR DRGs: 3.45 percent of claims will change APR DRG assignment having a net 0.25 percent payment reduction

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3M APR DRG groupers

- APR DRG V 31 (Oct 2013) is the first to support the complete ICD-10 CM diagnosis and procedures code sets.

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Those complexities, by definition, lead to important questions healthcare organizations should be ready to tackle| Julie Malida, Principal for Health Care Fraud Solutions in the Security Intelligence Practice, SAS Institute, : Gvt Health IT August 26, 2013

- How reliable is the data that is known, in order to re-map?
- How do you do trending and peer group analysis over time, and determine claims that are actually quality delivery of care vs. outliers worthy of scrutiny?
- Are there errors in the mapping, or worse yet, intentional misrepresentation of the facts, by creative billers?
- Will billers use a combination of ICD-9 and ICD-10 based on what might be more advantageous for their reimbursement, and say “oops” later?

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Iberic Peninsula Implementation

- Spain
- Portugal

Spain

- Target January 2016
- Spanish translation of ICD10CM and PCS completed Q1 2014
- 3M Training general modules (1,2,11,12 & first half of 13) translated and made available by MoH
- Rest of the modules 3M Training translated and made available by 3M
- Functionality of CCT2 under review
- APR DRG V31 will be implemented for inpatient episodes 2016
- IR DRG for ambulatory episodes

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Portugal

- Target January 2016
- Portuguese translation of ICD10CM and PCS
- APR DRG will be implemented for inpatient episodes 2015

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Canadian ICD10 Implementation lessons

My role back then

- Principal medical advisor from Quebec Ministry of Health for ICD10 implementation 1995-1997
- Comparison of ICD10CM-ICD9CM, ICD10 AU and ICD 10 : Conclusion: Quebec should move to American classifications
- Initial negotiations with WHO were stopped after Canadian agreement to develop ICD10CA
- Participation in the National Development and Implementation Committee 1997-1999

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Implementation of ICD-10-CA and CCI – A Checklist . Ref:

Moskal and Renahan-MEETING OF HEADS OF WHO COLLABORATING CENTRESFOR THE CLASSIFICATION OF DISEASES, Brisbane, Queensland, Australia, 14-19th October 2002

- Comprehensive planning
- Commitment to the process
- Constant communication
- User support
- Data quality checks
- Data analysis
- Impact analysis
- Ongoing maintenance and upgrades

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Phase I - Preplanning: 12 – 24 months ending on April 1 of the first fiscal year for submission of data in ICD-10-CA/CCI

Critical Success Factors -

- A comprehensive provincial plan
- Commitment to the project
- Communication, communication, communication
- Electronic Information technologies readiness
- Education targeted to the needs of each stakeholder
- Successful tools

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A comprehensive provincial plan

- Provincial, regional or local committees were struck that involved key stakeholders in the process either in an advisory or a task based capacity. Roles were defined and objectives established.
- A provincial leader/ project coordinator or team oversaw the whole plan.
- An environmental assessment or scan was done.
- Needs were identified along with the resource requirements.
- Funding responsibility and source of these resources was identified.
- Monitoring processes were established.

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Commitment to the project

- A broad range of industry sector stakeholders were involved – all levels of governments and their agencies, professional associations, colleges and universities, health-care facilities (management, service providers, support), vendors both computer (hardware/software) and CIHI.
- Every level of stakeholder, from the CEO to the front-line, was engaged in the process at some time.

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Communication is so important

- Every venue of communication needs to be employed.
- It is critical to keep all stakeholders, in the various loops, informed at all times with frequent written updates on progress, next steps, issue identification and resolution.
- It is important to touch base on a regular basis to ensure all feel supported in the process. Asking 'How's it going?' to anyone and everyone along the implementation line builds trust and support and, is often the first avenue for flagging issues that may impact on the successful completion of the project.

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Hardware, software readiness and computer literacy of end-users

- A detailed evaluation and plan for this aspect of the project is fundamental.
- Together with the vendor, define target dates for all deliverables and check in frequently to see if they are on target. Build contingencies into your plan. Unexpected glitches in making the transition to any new hardware or software are rarely an exception.
- Facilities with a high degree of computer literacy in the end-users, prior to the change, felt the transition was smoother. The learning curve wasn't as steep and the return to normal coding volumes was achieved in less time.

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Prepare presentations, access to materials, workshops=Key target audiences in this process were:

- Industry leaders and decision makers to achieve buy-in and support for this major undertaking in various sectors
- Hospital-based physicians to facilitate buy-in, changes in documentation and broad support
- Vendors of abstraction software to facilitate transition to a new standard and address internal needs
- Health record administrators and respective associations and colleges to achieve full integration of these new standards into coding practices.

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Successful tools

- Implementation Tool Kit
- Self-Learning Package (SLP)
- Two-day Basic Training Workshop
- Bulletins
- Fact sheets
- Development of provincial trainers/resource personnel - CIHI five-day Train the Trainer Workshop

It is recommended that the SLP be available 4 – 6 months ahead of going live and that the Basic Workshop be taught as close to going live as possible.

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Phase II - Start-Up: 3 – 6 months (April – September)

- This phase may be referred to as a testing phase. In this phase the vendor products both hardware and software are checked against deliverables and expected outputs and, a determination is made regarding knowledge transfer to the end-users/coders.

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Phase II- Key activities/issues

- Establish procedures for measuring and reporting on the functionality and quality of the inputs and outputs.
- Ensure the availability of in-house IT support.
- Communication, communication, communication
  - maintain a close relationship with vendors, CIHI and users to foster early detection and resolution of issues and problems. Identify time-lines whenever possible.
  - prepare all stakeholders for the likelihood of a slow down in coding and processing health records' information. Whenever possible have a back-up plan.
  - ensure that bulletins and updates from CIHI and vendors are shared in a timely manner with all appropriate personnel

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Phase II- Key activities/issues (cont'd)

- Provide ongoing technical and coding support to your coders. Ensure that coders have access to CIHI's online Coding Query Service, the most up-to-date Coding Guidelines and are able to attend refresher course and in-services, as appropriate.
- Data quality is everyone's responsibility. Teams may be required at multiple levels within the health-care system e.g. ministry, regional, local, facility.

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Phase III – User: 6 – 12 months
Communication,communication,communication

- maintain a close relationship with vendors, CIHI and users to foster early detection and resolution of issues and problems. Identify time-lines whenever possible.
- ensure that bulletins and updates from CIHI and vendors are shared in a timely manner with all appropriate personnel
- participate in committees to share experiences, learn from others, influence change

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Phase III- Learning is a life-long process

1. Ensure access to CIHI's online Coding Query Service, the most up-to-date Coding Guidelines and refresher courses and in-services
2. Identify needs and negotiate customization of workshops to meet incremental learning needs of coders and other end-users e.g. analysts

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Phase III-Data quality is everyone's responsibility :Teams may be required at multiple levels within the health-care system e.g. ministry, regional, local, facility.

- identify areas for further evaluation or requiring additional modifications in light of the data now being collected e.g. funding formula's, longitudinal analysis
- participate in data quality studies
- contribute to the development or revision of coding guidelines.
- contribute to the revision and enhancement of the next versions of ICD-10-CA/CCI.

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Phase IV – Ongoing Maintenance and Upgrading – infinity

Research, technology and ever expanding knowledge ensures that change is a continuous presence in our lives.

Active participation in the process is a key factor for a Pan Canadian success. The basic concepts for success remain the same. They too must constantly evolve to meet the changing needs.

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Coding speed productivity evaluation

- *Source:* ***Implementation of ICD-10: Experiences and Lessons Learned from a Canadian Hospital*** *Kerry Johnson, 2004 IFHRO Congress & AHIMA Convention Proceedings, October 2004*

- *Humber River Regional Hospital experience with transition from ICD9CM to ICD10*

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Coding Productivity (Charts Completed per Hour) Pre- and Post-ICD-10 Implementation-

Source: **Implementation of ICD-10: Experiences and Lessons Learned from a Canadian Hospital** *Kerry Johnson, 2004 IFHRO Congress & AHIMA Convention Proceedings, October 2004*

	ICD-9-CM (April 2002)	Start ICD-10 (July 2002)	ICD-10 (April 2003)
Inpatient	4.62	2.15	3.75
Day Surgery	10.68	3.82	8.53
Emergency	10.37	6.49	8.83

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Source: **Implementation of ICD-10: Experiences and Lessons Learned from a Canadian Hospital**
Kerry Johnson, 2004 IFHRO Congress & AHIMA Convention Proceedings, October 2004

- "…*It is noted that some of this (reduced performance in coding speed) may be accounted for by the transition in the coding tools, (that is, books to encoder and a software change). But what that effect would be is difficult to quantify, since the experience in productivity of this hospital is at least on par with many of its peer hospitals in terms of recovery from the implementation.*
- *It is noted that it was* ***at least three to six months post-implementation before there was any appreciable improvement in the decreased productivity and almost a year before productivity levels approached pre-ICD-10 levels***. "

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Medline (Pubmed) review on ICD10 CA implementation-resulted in 45 English speaking published papers-6 by Quan et al.

Most relevant: Health Services Research

Volume 43 Issue 4, Pages 1424 - 1441

Published Online: 7 Jan 2008

Assessing Validity of ICD-9-CM and ICD-10 Administrative Data in Recording Clinical Conditions in a Unique Dually Coded Database

Hude Quan 1 *, Bing Li 2 , L. Duncan Saunders 3 , Gerry A. Parsons 4 , Carolyn I. Nilsson 5 , Arif Alibhai 3 , and William A. Ghali 6 for the IMECCHI Investigators

1 Department of Community Health Sciences and Centre for Health and Policy Studies, University of Calgary

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Methods. *HSR Quan et al 2008*

"*Were reviewed **4,008 randomly selected charts** for patients admitted from January 1 to June 30, 2003 at four teaching hospitals in Alberta, Canada to determine **the presence or absence of 32 clinical conditions and to assess the agreement between ICD-10 data and chart data**.*

*The **same charts were recoded using ICD-9-CM** and determined the agreement between the ICD-9-CM data and chart data for recording those same conditions. The accuracy of ICD-10 data relative to chart data was compared with the accuracy of ICD-9-CM data relative to chart data*."

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Results. *HSR Quan et al 2008*

" *Sensitivity values ranged from 9.3 to 83.1 percent for ICD-9-CM and from 12.7 to 80.8 percent for ICD-10 data. Positive predictive values ranged from 23.1 to 100 percent for ICD-9-CM and from 32.0 to 100 percent for ICD-10 data.* ***. Specificity and negative predictive values were consistently high for both ICD-9-CM and ICD-10 databases***

Of ***the 32 conditions assessed, ICD-10 data had significantly higher sensitivity for one condition and lower sensitivity for seven conditions relative to ICD-9-CM data****.*

The two databases had similar sensitivity values for the remaining 24 conditions."

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Conclusions . *HSR Quan et al 2008*

- ***"The validity of ICD-9-CM and ICD-10 administrative data in recording clinical conditions was generally similar though validity differed between coding versions for some conditions. The implementation of ICD-10 coding has not significantly improved the quality of administrative data relative to ICD-9-CM.*** *Future assessments like this one are needed because the validity of ICD-10 data may get better as coders gain experience with the new coding system."*

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Summary of Canadian experience from CIHI point of view

- Planning is essential
- Collaborative effort is of the essence
- Coding tool training essential
- CCI (interventions) more difficult than ICD10 diagnoses
- Productivity came back to par after 6-12 months time window
- Needed feedback and retraining one year after implementation

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Conclusion

Dank U Merci!