Part B Insider (Multispecialty) Coding Alert

ICD-10 : Don't Expect Outrageous Transition Times to

Plus: Physicians shouldn't have to bend over backward to change how they document their records for coders to find accurate ICD-10 codes.

If you've heard that your staff members won't be able to effectively code a medical chart using ICD-10 codes unless they've had years of training, you've heard wrong, according to a recent CMS call.

Last May, a formal testing process took place to "assess the functionality and utility of applying ICD-10 codes to actual medical records in a variety of healthcare settings and assess the level of coding training required," according to **Sue**

Bowman, RHIA, CCS, director of coding policy and compliance at AHIMA. Bowman shared information about the trial run during a Nov. 12 CMS-sponsored ICD-10 National Provider Call.

During the testing, credentialed health information management professionals who had no prior ICD-10 experience coded 6,177 medical records. Prior to the test, the participants received two hours of non-interactive training, and their coding

accuracy and understanding of how to use ICD-10 were "surprisingly good," Bowman said.

Outcomes Looked Positive

Results showed that ICD-10 was found to be a "significant improvement" over ICD-9, and ICD-10 was more applicable to non-hospital settings than ICD-9, Bowman said. Only 12.3 percent of the reported ICD-10 codes in the project were billed as

"unspecified," indicating that documentation required to support ICD-10's specificity was in most of the medical records, which means that ICD-10 codes can be applied to today's medical records without having to change documentation practices

significantly.The participants who coded the records said that ICD-10 "wasn't nearly as hard as they thought it would be," leading AHIMA to conclude that "intensive coder training" should occur three to six months prior to implementation,

Bowman said.

Physicians Shouldn't Stress

The CMS call also allowed participants to dispel one lingering ICD-10 myth -- that physicians would have to overhaul their documen-tation practices.

"I think the biggest concern I've been hearing from physicians is, how much more work is this going to cause me? And the reality for physicians, as far as your documentation goes, is none -- absolutely none right now," said **Jeffrey Linzer, MD,**

associate professor of pediatrics and emergency medicine at Emory University School of Medicine, during the call.

Prep your superbill: "Probably the biggest work physicians will have to be concerned about is expanding their superbills," Linzer said. "If you have diagnosis codes now on your superbill that you'd check off for things like an ear infection, you

could add acute or chronic, or right or left, to the code options" once ICD-10 goes into effect.

Prep your physicians: In a statement sure to get coders cheering, Linzer pointed out that physicians should use terminology that helps coders select the right code.

"Right now, physicians are not writing down terminology that is helpful to the coders who are helping us do our work, and that's why the coders are coming back to you now asking you to clarify what you've written as a diagnosis, because they

need to be able to pick it out of the ICD-9 book," Linzer said. "That's not going to change with ICD-10; it's just going to make it easier for them to take the specific information that you're already writing in the medical record and being able to apply

a code to that."

To read more about ICD-10, or to review the presentation from the provider call, visit the CMS Web site at http://www.cms.hhs.gov/ICD10.