ICD-10

A PHAZ VIEWPOINT

SOME FACTS & OPINIONS

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USA BASED

- Follows ICD-9
- ICD-10CM (Clinical Modification) - First Edition issued in 1999
- A more complex coding system with 5 levels of coding
- In 2009, deadline of October 1st 2014 for transition from ICD-9 to ICD-10 set by the (USA) Department of Health and Human Services.
- In September 2012 American Medical Association (AMA) published a 21 page document "….. 12 Step Transition Plan for ICD-10"
- 1 April 2014 the "***Protecting Access to Medicare Act of 2014***" set a new compliance date for the use of ICD-10 to be operational by 1 October 2015.
- June 2014, AMA published an 8 page document "Transition to ICD-10"

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Continued

- The ICD-10 Instruction Manual is 201 pages long
- The ICD-10 Tabular List of Diseases and Injuries is 1,593 pages long
- The ICD-10-PCS Tables & Index Document Code List is 1,509 pages long
- I have a 2013 document titled “Four Things Doctors may like about ICD-10” (Medscape).

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SOUTH AFRICA BASED

- ICD-10 implementation began in ± 2000, having previously implemented ICD-9

- 18th October 2012 the document "***USER GUIDE: Technical User Guide compiled by the Ministerial ICD-10 Task Force Team to define standards and guidelines for ICD-10 coding implementation"*** published.

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SOUTH AFRICAN ICD-10 IMPLEMENTATION PHASES

- A phased approach starting on 1 July 2005 has been followed to implement ICD-10 coding in South Africa as described in the CMS Circular 32 of 2005.
- **Phase 1**: Implementation period from 1 July 2005 to 30 September 2005
- **Phase 2**: Implementation period from 1 October 2005 to 31 December 2005
- **Phase 3**: Implementation period from 1 January 2006 to 01 January 2014
- **Phase 4**: Implementation has been further phased into 4.1. and 4.2.
- **Phase 4.1**: Implementation period starts with displaying warning messages from 01 June 2013 based on the new data requirements i.e. age, gender, morphology codes. This phase will be fully implemented on 1 January 2014 with full claim validation rejections.
- **Phase 4.2**: Implementation details will be finalized in 2013 and communicated to all healthcare stakeholders

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SOUTH AFRICAN IMPLEMENTATION EXPERIENCES

- Essential to have doctors involved in and responsible for determining the diagnosis code
  - Pre-coding by the doctors rooms at time of booking should be considered
  - It has been found that incentives are necessary both legal and financial
  - Doctors' input is still a problem after more than 10 years
- Doctor "Incentives"
  - Legal
  - Financial

    In SA the hospital and doctor payments are linked.

    Payment to Dr is linked to Dr providing the code

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CODERS

- The main coding tasks are carried out by Case Managers, who must have a (any) clinical background – usually nursing.
  - In SA there is a Case Managers Association with a website
  - Coders should not select the diagnosis code – must be by a doctor
  - Coders should verify the code by checking patient notes etc
  - A Code of Ethics to include these requirements is in the drafting stage.
  - Coders should have talents for:
    - Coding
    - Being factual
    - Research mentality
    - Categorisation
    - Being Specific & detailed mindset

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CODING ISSUES

- Coding should be done during the admission period as opposed to after discharge.
- Even a trained coder will have difficulty in arriving at a correct code by researching patient notes.
- It is of note that some South African mines chose to code ‘administratively’ after discharge. This proved to be disastrous from the point of view of obtaining useful data.
- Coding post discharge should be avoided at all costs
- Advice is to go straight into deep level coding as opposed to commencing with the initial 3 digit code alone.
- The amount of time and resources required for coding should not be under estimated.
- In one small specialist hospital It takes 3½ coders 50% of their time to code 35 patients a day.

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TRAINING

- Training is the key to success
- ‘On-line’ training does not replace the ‘classroom’ type of training.
- In RSA the experience is that a coder needs an initial 3-4 day training and then only becomes useful after 4-5 months. This depends on the existence od experienced colleagues at the workplace.
- A ‘train-the trainer’ program may be necessary for Zimbabwe, which may require importing a trainer

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FUNDING TRAINING

- Training is a key requirement and is costly
- Not sure how training in SA is funded
- Training is not cheap (in USA $6,200 per person overall)
- There should be no short cut and training should be ongoing
- Funding training is a key pre-requisite and would need in-depth debate to find a solution for Zim

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BENEFITS OF ICD-10 ?

- For the provider
- For the funder
- For government
- For epidemiological purposes

- If there is no motivation or general interest there will definitely be problems.
- With ICD-10 data, what decision making will there be and by who?

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PUBLIC HOSPITALS

- **The MoH&CC operate an ICD-10 coding system which is implemented in retrospect by medical records departments.**
- **This perception is not verified, but if correct, the lack of 'live' clinical input can only lead to false information (and therefore not credible)**

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CPT-4

- CPT = Current Procedural Terminology
- This could be useful
- Much easier to implement than ICD-10
- CPT is not a substitute for ID-10

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IT ISSUES

- Hospital Information Systems (HIS) should ideally be ICD-10 and CPT-4 ready with the loaded codes updated on a regular basis. There are several HIS systems with these features loaded.
- Trimed is the only one I am aware of.
- ICD-10CM code search engines are readily available. They do not however replace the experienced decoder
- There may be a place to incorporate such search engine technology to link up with the ICD-10 loaded HIS software.
- Certainly it would appear that ICD-10 coding would need to be computer based

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ACCEPTABILITY OF ICD-10

- ICD-10 has proved unpopular with providers – all of no benefit (zero advantage) to them:
  - It is not a ‘by-the-way’ or ‘part-time’ task – it is a dedicated task
  - Considerable extra work is required
  - More staff required
  - Costly training

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THANK YOU

I am sure there is much more to this complex subject

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