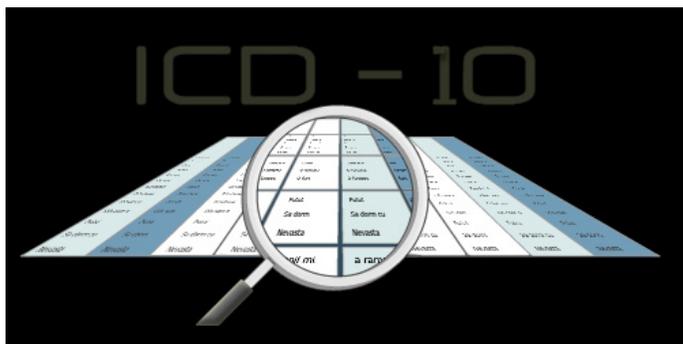


*Conversion to ICD-10 mandated for 2014*

# UCHealth Prepares for Major Coding Change

University of Colorado Health is preparing for entry into a brave new world of coding and documentation.

The U.S. Department of Health and Human Services (HHS) has mandated the replacement of the ICD-9-CM/PCS code sets used to report health care diagnoses and procedures with ICD-10 codes, effective Oct. 1, 2014. Moving from 9 to 10 might not sound like a big deal, but it is.



In fact, it's one of the biggest changes HHS is asking hospitals to make in an era already defined by health care upheaval. Converting to ICD-10 affects not only coders, but many other hospital providers, including nurses, physicians, clinical documentation specialists and billers.

Fundamentally it will affect UCHealth as a whole and each hospital that is part of it, including UCH, because federal and commercial payers base reimbursement rates on the ICD system. Complete, accurate coding means hospitals receive payment commensurate with the diagnoses, procedures, treatments and services they provide.

With ICD-10, coders will have much more information to manage. The new system adds tens of thousands of new alphanumeric codes and demands a far deeper level of documentation and coding specificity than ICD-9 does. In addition, coders will have to know

both versions, since documentation for many patients will overlap the October 2014 conversion date.

*“As Sandy Brewton, inpatient coding supervisor for UCHealth put it, ‘Coders and billers will have to be fluent in two languages. It won’t be a matter of switching to ICD-10 on Oct. 1, 2014 and that’s it.’”*

**Getting ahead of the curve.** The conversion is 18 months away, but UCHealth has already launched a massive education and training effort to prepare for it. Coders – there are 34 at UCH and some 150 across the system – have begun intensive training, paid for by UCHealth, said Tracy Olsten, ICD-10 program manager.

The three-part online education program includes lessons in medical terminology; additional coursework in physiology and anatomy; and specific education in ICD-10 for practice in applying the knowledge to various clinical scenarios. Clinical documentation and coding staff will have face-to-face training sessions that will begin near the end of 2013, Olsten said.

The education and training will continue through 2014 in preparation for the transition date. Brewton said coders get two hours of “downtime” a week to work on the educational materials for ICD-10.

“The big advantage is everyone is getting trained on the same program,” she said.

The ICD-10 leadership group has also reviewed some 10,000 medical records, looking for areas in the documentation that could affect clinical and financial operations when UCHealth implements ICD-10. Olsten said the lessons learned from this exercise and meetings with departments over the next few months will inform department-specific training.

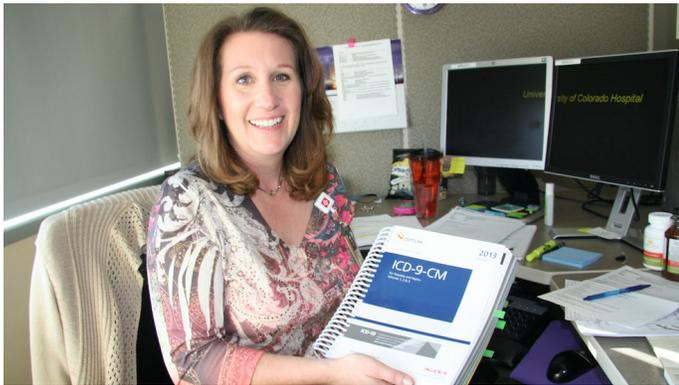
UCHealth will begin dual ICD-9 and ICD-10 coding Jan. 1, 2014; testing with payers will start April 1, 2014.

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**Group learning.** Through 2013, the ICD-10 team will also provide training, targeted education and additional resources to physicians, clinical documentation and referral specialists, and anyone else who wants it, Olsten said.

Meanwhile, the Epic team is at work preparing the electronic medical record (EMR) for ICD-10. One tool in development is a “diagnosis calculator,” which will prompt physicians to add documentation for a more complete, accurate – and codable – record. Another will electronically “map” documentation to the proper ICD-10 code, Olsten explained.

Sharpening up documentation to enable accurate coding the first time helps back-office staff and caregivers alike.



*Inpatient coding supervisor Sandy Brewton with ICD-9 manual, today the coder's Bible. The far more complex ICD-10 system will replace ICD-9 in about 18 months.*

“The more information that is in the medical record, the fewer questions support staff will have to ask and query the providers,” she said. There are fringe benefits to getting records right the first time, too. It should help the system’s hospitals demonstrate compliance with patient safety requirements, clinical core measures and other quality indicators that federal and private payers are already demanding, Olsten added.

**Let physicians practice.** At the same time, the ICD-10 team wants to minimize pressure on physicians who don’t have time to remember procedural codes or thumb through thick manuals to decide whether to use the word “kidney” or “renal.” Yet the new system does demand more of them, said ICD-10 educator Theresa Fleskes. Specifying the right or left side in documenting a fracture (*see sidebar*) is an example, she noted.

“That’s not something they are used to putting in,” she said, “and there are lots of little details to remember. But no physician wants

to be learning coding.” Fleskes said educators will work directly with providers to help them understand the changes and how to document the EMR with as much precision as possible right from the start.

## The Deep Dig of ICD-10

To illustrate the difference in complexity of ICD-10 coding, program manager Tracy Olsten cited the example of an open wrist fracture. The new system will require coding the side on which the fracture occurred (right or left); the specific bone (the wrist has eight); and the joint space (there are four). Additional documentation could include if the treatment visit is the initial or a subsequent encounter, whether or not the healing is on track and much more.

“Our documentation as an organization needs some overall improvement,” Olsten said. “We will be assisting the medical staff and guiding them as to the changes ahead.”

The level of detail in ICD-10 is sometimes a surprise even to a seasoned coder like Sandy Brewton, who has spent 20 years in health information management.

“We will need to understand body systems and organs and the procedures being performed,” she said, noting the new system includes 31 “root operations,” which define the objective of a procedure. Some of the procedures have new descriptors, such as “extirpation,” ICD-10 lingo for cutting solid matter from the body.

“I thought I knew a lot,” Brewton said, “but some of the terminology will be difficult to remember.”