Thousands of records for new codes

Conversion to ICD-10 an Epic Undertaking

Amid construction projects, system-wide integration of medical records, staff hiring and shuffling, and other visible signs of change, University of Colorado Health quietly continues a massive project that will ultimately affect not only its member hospitals but the entire health care system.

It's the conversion to ICD-10 (short for International Classification of Diseases, version 10), the coding system used to report diagnoses and procedures. By mandate of the U.S. Department of Health and Human Services, ICD-10 will replace the ICD-9-CM-PCS code sets at all U.S. hospitals on Oct. 1, 2014.

This is a massive change, affecting nearly everyone involved with patient care as well as finance, compliance, reporting and other staff. International Classification of Diseases codes are how health care organizations track, report and, ultimately, bill for the care they deliver.

Tracy Olsten manages the massive project to transition UCHealth from the ICD-9 system for coding procedures and diagnoses to ICD-10.

ICD-10, used in every country in the world except the United States, contains nearly five times as many diagnostic alphanumeric codes as ICD-9. The roughly 55,000 additional codes for diagnoses provide for a far deeper level of detail in clinical documentation, but they also present a formidable challenge in terms of technical preparation and education for staff and providers.

The conversion to ICD-10 also requires upgrading the Epic electronic medical record (EMR), a process that includes reviewing the current record to find all instances of ICD-9 codes; building a new version of Epic to accommodate ICD-10 codes; and testing the new EMR to iron out kinks before go-live.

The review process, now complete, first required a scan of the current build of Epic to identify what turned out to be some 5,200 records that use or might use ICD-9 codes, said Brad Runzel-Williams, RN, Health Information Management business system analyst for the Epic team.

"We saw that virtually every application will have some piece of ICD-10 code," he said.

Found in translation. With the scan complete, the team created a stand-alone test environment to update reports used by providers throughout the hospital — relating to patients on treatment plans with a specific diagnosis, such as stroke, for example — with ICD-10 codes. Some ICD-10 codes correspond directly to an ICD-9 equivalent, but many others are new and have to be imported. The environment includes both ICD-9 and ICD-10 codes as the hospital will be dual-coding, starting April 1, 2014, until the Oct. 1, 2014 milestone.

A "translation tool" from 3M helps match ICD-10 codes to the proper diagnosis-related groups (DRGs) used in ICD-9, but it's far from a one-to-one exercise. That's because ICD-10 captures much more detailed diagnostic and procedural information, including body system and part, type of operation, approach (such as an open

procedure), and devices used. More often than not, an ICD-9 code doesn't approach that level of specificity.

> *"Some of the conversion is automated, but the majority will be manual," Runzel-Williams said. "An ICD-9 code may map to 10 codes in ICD-10."*

Cracking the code. Tracy Olsten, ICD-10 program manager for UCHealth, said the assessment and testing phases for the project are on schedule. Education for ICD-10 "subject matter experts" throughout the UCHealth system will begin in July, she said. There will be at least 15 of these super users at each hospital to serve as resources to others. Her team also plans to provide online education and face-to-face "coffee chats" for coders to compare notes on challenging cases.
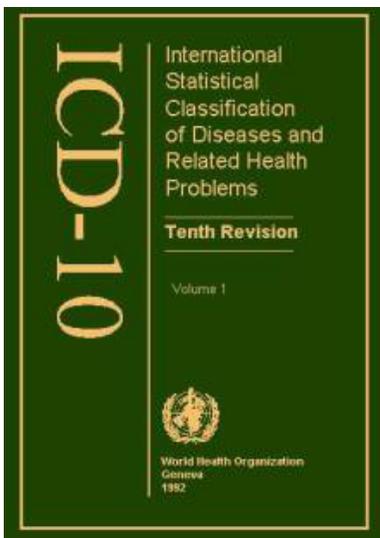
The biggest concern now is finding ways to help make documentation as easy as possible for physicians as UCHealth makes the transition to ICD-10, she said.

"We want to find out what best suits physicians and will have the least impact on their workflow as possible," Olsten said.

It's a critical challenge because documentation of the medical record is the backbone of the codes submitted to payers for reimbursement. Olsten said UCHealth is working with Epic physician champions and physician leaders, including UCHealth Chief Medical Information Officer CT Lin, MD, to discuss tools to lighten the documentation load.

These include "smart sets," an Epic feature that opens a list of diagnoses and treatments when a user types in a symptom; or "dot phrases," short abbreviations that bring up the same list.

Perhaps most important to physicians will be a "diagnosis calculator," designed to ensure they don't have to memorize ICD-10 codes. If a physician enters an unspecified code in the EMR, for example, the calculator will produce a list of specific ICD-10 codes for him or her to choose from, Runzel-Williams said. If the physician adds a diagnosis – specifying a hip fracture as open, for example – the calculator will show a list with the proper code.

"Everything rests on provider documentation that allows coders to interpret and do their piece of the process correctly," Runzel-Williams said.

That's essential to ensure that the hospital is properly reimbursed for the services it provides. But the importance of ICD-10 doesn't stop there, Olsten says.

"It's not a coding issue alone," she said. The information in the EMR, she pointed out, is used to document the hospital's adherence to core measures of quality and safety, as well as its compliance with federal regulations and patient outcomes.

"If you encounter any patient and enter any diagnosis code in the medical record, ICD-10 affects you," Olsten said.