American Society of Anesthesiologists®

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ICD-10-CM/PCS: Thirteen Months and Counting…..

The ICD-10 code sets (ICD-10-CM diagnosis codes and ICD-10-PCS hospital inpatient procedure codes) are scheduled for implementation on October 1, 2014. Only the ICD-10-CM code set affects physician claims. Although physician organizations are still vigorously campaigning to delay ICD-10 implementation, there is no indication at this time that any delay will be forthcoming. Given that, anesthesiologists should begin to prepare now for the upcoming implementation.

It is important for anesthesiologists to understand that the new ICD-10 coding system will not change how anesthesiologists report the procedures they perform. Procedures will still be reported with CPT® codes 00100-01999 for anesthesia procedures and the other CPT codes for non-anesthesia procedures, such as line placements, pain medicine procedures, TEE, etc. In other words, CPT codes will still be used to report **what** was done.

The ICD-10-CM codes are used to report the diagnosis codes that necessitated the anesthesia services, or **why** the services were provided. Many payers, including Medicare, link the diagnosis codes to the procedure codes to assess medical necessity. For example, payors may deny payment for a cholecystectomy (and anesthesia for that procedure) if the reported diagnosis codes do not describe gall bladder disease. For providers submitting claims to payers with advanced claims systems, matching procedure codes to diagnosis codes is essential to getting paid in a timely manner.

Because ICD-10-CM codes are different than ICD-9-CM codes, and not just an expansion of that system, it is important to develop some familiarity with the new code set. The new codes require more detailed use of anatomical data, timing of the treatment provided (initial treatment, follow-up treatment, or treatment of complications), and greater specificity of the type of injury or disease. For example, ICD-10-CM coding requires open fractures to be designated not only by their location, but to also identify which of the seven types of open fractures is being treated according to the Gustilo open fracture classification system. Correctly reporting these codes will require greater communication between anesthesiologists and surgeons.

Coders who prepare claims for anesthesia providers will need to become very familiar with a code set that has almost 70,000 individual codes, as opposed to the current 13,000 codes. This increase is not as startling as it may initially seem because much of the increase is accounted for by specific laterality codes (right and left body parts have separate diagnosis codes), greater anatomical granularity, timing of episode of care, greater specificity of pregnancy trimester, and other similar details. Coders will need to have greater knowledge of anatomy and physiology and physicians will need to provide more detailed information in their documentation to allow coders to select the appropriate code.

One criticism of ICD-10 adoption has been that while a tremendous burden falls on physicians to switch to the new code set, there is little indication they will benefit from these changes. However, with the recent push to ACOs, bundled payments and other alternative payment systems, ICD-10-CM codes may allow for more granularity of information regarding the patients' medical conditions. Bundled payments may be risk adjusted to account for the increased risks presented by patients with increased morbidity. Without accurate diagnosis codes, it will be difficult to develop those risk adjustments or to document why payments for individual patients should be at a higher rate. The ICD-10-CM diagnosis codes may be useful in establishing the basis of risk adjustments.

Assuming that conversion to ICD-10-CM is inevitable, it is important for anesthesiologists to prepare in advance for this transition because once the switchover date passes, claims submitted with ICD-9-CM codes will be rejected, resulting in non-payment of those claims. While many payers will likely allow for those claims to be resubmitted, they may adhere to their timely filing deadlines, which means that if anesthesiologists wait until after the switchover date to begin preparing to report ICD-10 codes, they may miss out on the time limits for some of their claims, resulting in permanent loss of revenues for those services. To avoid cash flow disruptions, anesthesiologists must be prepared to utilize the new code set when required to do so.

To help our members prepare for ICD-10 implementation, the ASA has conducted educational presentations during the past two ASA Annual meetings and will do so again in San Francisco this coming October. ASA will post information on how to prepare for the transition on our website as CMS and other sources release it. Individual coders will likely begin preparing for the ICD-10 transition about 6-9 months prior to the switchover date. That preparation will provide a strong foundation for them to report anesthesia services. It will also provide a background for them to educate physicians about the information they will need to appropriately and correctly report services provided.

That said, it is not too early for anesthesiologists to prepare their office systems for the new ICD-10 codes. This may require reprogramming of office billing systems, electronic records, etc. Also, because ICD-10 coding requires more information, anesthesiologists would benefit from beginning to document now as if their claims were being submitted with ICD-10 codes. By doing so, that will be second nature when such documentation is required after the transition.

Even if anesthesiologists prepare for this transition, there are likely to be delays in payments, whether due to reporting errors by physicians or payer claims system issues that result in incorrect or non-payment of valid, properly submitted claims. Practices without sufficient cash reserves to tolerate up to six months in delayed payments might consider establishing a line of credit now, before any problems exist, to have the ability to meet their financial obligations should payments be temporarily curtailed.