THE READINESS IS ALL:
HOW STRUCTURED DATA IS THE SOLUTION TO ICD-10 CONCERNS

"If it be now, 't is not to come; if it be not to come, it will be now; if it be not now, yet it will come: ***the readiness is all.****"*

-- *Hamlet*

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MORE CODING, MORE PROBLEMS

In a few years (by October 1, 2013 to be exact), the US will adopt ICD-10 as the official (and sole) system for coding diagnoses. This will mean that the volume of codes available for diagnosing patients and samples will increase from 14,000 to over 155,000 different codes. This astronomical expansion of the numbers of codes is a way of addressing the need for greater refinement of codes and data capture.

However, this increase in codes will have serious repercussions on the way procedures are documented, information is captured and the way that health professionals will be paid. For physicians, including surgeons and pathologists, a lack of knowledge of this issue may result in a decrease in pay or even fines.

In this paper, I will show what the ICD-10 is, how health professionals should approach it, and what physicians need to do to strengthen their preparation for this fundamental change in coding and in documentation.

BACKGROUND: HISTORY OF THE ICD SYSTEM

International Statistical Classification of Diseases and Related Health Problems (commonly referred to as ICD) is a set of codes used to properly identify and classify issues facing patients – including diseases, injuries, infections, diagnoses, symptoms and other afflictions. Published by the World Health Organization (WHO), ICD is used by health professionals for billing/reimbursement, data capture and other informational purposes. The roots of ICD can be dated back to 1893, where a meeting of international physicians decided to adopt the "List of Causes of Death." As time went on, and the focus expanded beyond morbidities, the system was adopted by various countries as the official way of tracking Diseases and Health problems. In addition, ICD-10 is used in conjunction with diagnosing pathologic samples (particularly in cancer cases, although it is not restricted to neoplasms).

The most recent iteration, and the cause for some stateside concern, is ICD-10. ICD-10 was begun in 1983, but it wasn't finished until 1990 and came into use by WHO nations in 1994. Well…it came into use by a lot of them. Many countries have adopted ICD-10 as the official coding system for diseases and health problems – particularly United Kingdom, Germany, Canada, Australia, France, Sweden, Korea and Thailand. But the United States has not adopted it yet. If one were to review the coding attached to medical forms today, the coding system that she'd be viewing is ICD-9. However, there are plans for utilizing ICD-10 in the US – setting the date for implementation as October 1, 2013 (as previously mentioned).

Additionally, many countries (including Canada and Germany) have modified the original set of ICD-10 codes to tailor it to their countries' particular need and goals for diagnosis and data capture. When the US adopts ICD-10, it will not be the basic, vanilla

type of ICD-10 initially implemented 16 years ago. The US health care system will be using ICD-10 Clinical Modification (or ICD-10-CM), a revision that incorporates our own specific needs to adhere to compliance with various professional organizations and health standards.

REPERCUSSIONS, PART 1: CRISES PRECIPITATE CHANGE

The States will finally catch up to the rest of the world and will be on the same coding page. And, as the codes are much more specific and allow for deeper research, this will only improve medical advancements and increase knowledge being captured and communicated in the medical community. And yet – there is a sense of unease creeping into many Health Information Manager's offices; nervousness abounds about the sea change that is about to hit in Health Records and the mammoth change in behavior and reporting that ICD-10 necessitates.

Since there are so many more codes in ICD-10 than ICD-9, will it be harder for coders to identify the codes that best correlate to the diagnoses the physicians gave? Will all of the computer programs that use ICD-9 be updated in time for ICD-10′s implementation? Are we about to grind our healthcare system to a complete standstill or is all of this just much ado about nothing?

According to Rhonda Butler, senior clinical research analyst for 3M Health Information Systems, the changes preparing to hit US health facilities in 2013 is more a source of promise than it is a cause for panic. In a piece she wrote for the AHIMA newsletter[1], Ms. Butler is quick to point out that most of the concerns are based on outdated and obsolete beliefs. In an age where computers have outstripped humans' ability to memorize thousands of individual codes, and we have many programs capable of searching massive lists to find what we are looking for, the ability to adopt and adapt to ICD-10 is well within our reach. As Butler writes,

> Yes, ICD-10 is coming. And yes, there is a lot of work to do. But it is not the end of the world as we know it. Getting work done well takes planning, attention to detail, persistence, cooperation. Sometimes finding reasons not to work is more appealing than doing work. [2]

For the most part, there is a 1:1 correlation between ICD-9 codes and ICD-10 codes. Obviously, it's not that way throughout the two versions. But for those diagnostic instances where there are more ICD-10 codes than ICD-9 counterparts, it's not because they are all more convoluted or vague. The increase in ICD codes is to better specify what the health professional meant. Many codes in ICD-9 (that is to say, many of the codes being used right now in US hospitals) are very much all-encompassing/one size fits all.

For example, a common, ICD-9 preoperative diagnosis for a laparoscopic cholecystectomy would be "156.8 – Malignant Neoplasm of Other Specified Sites of gallbladder and extrahepatic bile ducts." Now that diagnosis will be winnowed down to the much easier to understand ICD-10 "C24.8 – Malignant neoplasm of overlapping sites

of biliary tract." Perhaps, previously, that wasn't what the physician was talking about – but that isn't a case for ICD-9 or a strike against ICD-10. If C24.8 wasn't what the physician had meant, then clearly Code 156.8 was too broad or vague to allow for such open interpretation.

REPERCUSSIONS, PART 2: WHY THIS MATTERS TO PHYSICIANS

There is more cause for promise than panic, Ms. Butler writes. However, it should be noted that not panicking is not the same as not preparing. Upon discovery that reimbursement and risk management may hinge upon proper coding of medical reports, many physicians become acutely aware of the importance of assigning the correct codes. Health professionals don't have to know the intricacies and subtleties inherent to these coding systems – but they do have to know why it's important and why they should care about it.

In addition to the standards and guidelines put out by such organizations as the Joint Commission, College of American Pathologists (CAP), and the American Medical Association (AMA), physicians will now have to comply with better documentation in order to ensure proper coding and therefore proper reimbursement to the facility and to the physician himself. Incomplete documentation not only weakens risk management against potential litigious issues but also translates into being paid less than the health professional should be. Furthermore, the tactic of overcompensating for these fears – that is to say bombard the system with an abundance of information in the vain hope that the data HIM needs to properly code the report – will only add to the problem as it will take coders more time to comb through verbose passages trying to find pertinent information.

In addition, budgetary spending for conversion to ICD-10 may also result in a decrease of spending other areas[3]. Therefore, the more prepared the facility and the more informed the staff, the easier the conversion will be. Once systems are in place to properly guide health professionals to this new coding, then these professionals can feel assured that there won't be any financial penalties or bureaucratic disasters caused by ICD-10. To put it simply, if a facility is properly prepared for ICD-10 conversion, then the workers of that facility will not lose money due to improper coding. If health professionals are fully informed and aware of the need to properly document and code information, then the facility will not lose money due to improper coding.

STRUCTURED DATA = STRONGER DATA

What is the best way to ensure that the correct information is being captured? How can physicians know that the important data needed to correctly code reports (and therefore, properly pay the physician) was recorded? The answer isn't new, but it does necessitate a willingness to augment the current workflow of most health facilities.

The questions every physician needs to ask him- or herself when documenting a case is: "How will this data ultimately be used?" and "how am I ensuring that the data I capture will be put to that use in the most efficient way possible?"

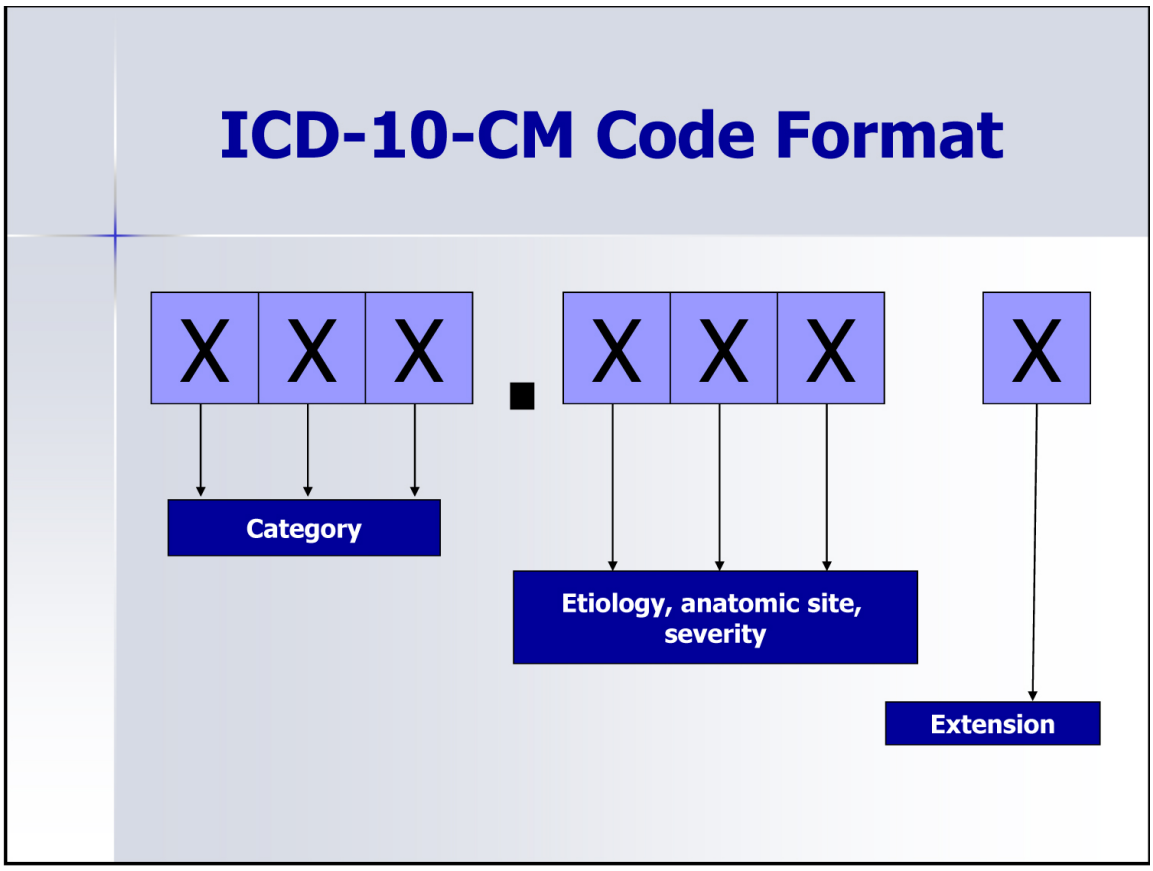
When physicians generate reports (pathological, postoperative, etc.), they usually do so using the dictation and transcription method. There are some requirements to what information is captured in that report, like the CAP Cancer Checklists, but there is no definitive form that must be filled out. A lack of consistency promotes a lack of standardization. HIM workers then have to apply standards and structure to this inconsistent, unstructured document in order to pay the physician correctly. Why can't everyone speak in the same language?

That's not a suggestion for physicians to become coders. It is a call to encourage completeness of reports, compliance with national/internal standards, and adherence to a consistency in reporting. Such measures would strengthen research and risk management while also promoting proper payment for services rendered. Structured data is the way to make certain that these measures are adopted into current reporting and workflows.

Structured data is a system of isolated points of information that are easy to reference, research and use however one sees fit. When formatted in such a manner, data becomes easier to see, easier to find, easier to use. It is most assuredly different than unstructured text – but it's not inferior. Nor is it a new system of interpreting the world or recording events. Structured data is everywhere: instructions for assembling furniture, programming your Smartphone, your email program, searching for books on Amazon.com.

Much of the information that is captured at a health facility is in structured form – from the schedule to vital signs. Structured data enables health professionals to look up patients by age, sex, nationality or specific ailments. Pieces of information are isolated in unique fields where they are readily available whenever they are needed. And each piece is brought together with related pieces of data so that one bit of information is now part of something larger – every Big Picture is built on the contributions of multiple pixels. Structured data allows a specificity that eludes records when there is no formatting. It is the foundation for creating a universal language that will inform decisions and treatments and whole schools of thoughts in the medical world.

ICD-10-CM codes are already structured data. Each character in its 3-7 character long code corresponds with a piece of information – part of the body, severity of issue, origin of disease, age of patient, etc. The information that is the basis for these codes originates in the medical documentation of pathologists, surgeons and others. If the documentation is already in a structured format, there is no ambiguity about what occurred or any need for subjective interpretation of the report.



(Taken from presentation "Diagnosis Coding the ICD-10 Way" given by Lynn Kuehn at MaHIMA meeting, 9/22/10)

With all of the other reporting requirements, why further complicate the issue? Satisfy CAP protocols, Joint Commission guidelines and create better documentation for more accurate coding and better payment – all at once. Structured data, captured through electronic synoptic reporting, guarantees that the necessary information is documented and does so in a very clear, consistent manner that makes it much easier for other people to find the desired information. Students and medical interns can easier understand processes and best practices; billing can easily see what occurred and what it will cost; physicians can read pathologic and postoperative reports very easily and quickly to learn what their next steps will have to be.

If the process for documenting this information is already structured data through synoptic reporting, then health facilities will be even greater prepared when October 2013 comes along, bringing ICD-10 with it. By being used to work in the structured data environment, physicians are ready to make sure all of the vital information is captured in their reports, they are ready to automatically generate the correct ICD-10 code, they are ready to streamline documentation and communication between departments in their facilities and they are ready to be paid correctly for the hard work they have put in.

[1] http://www.ahima.org/images/Newsletters/ICDTen/2010/April/ICD10Invasion.html

[2] ibid;

[3] http://www.darkdaily.com/good-news-for-labs-hhs-delays-implementation-deadline-for-icd-10-to-2013-version-40104010a1

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