Converting to ICD-10: Challenges and Impacts for Health Care Providers

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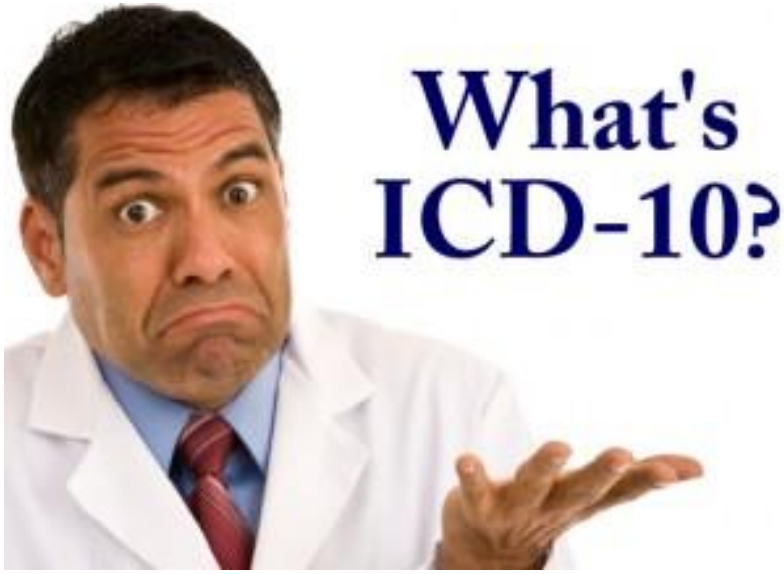

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Dr. Christopher Sullivan, PhD, is the President and CEO of Image Research, LLC, a communication consulting firm that specializes in health care informatics.

Image Research offers expertise in:

- Privacy and Security of Health IT
- Implementing Electronic Health Record systems and Meaningful Use
- Strategic planning and training for the transition to ICD-10
- Health Information Exchange

Dr. Sullivan is an adjunct faculty member at Nova Southeastern and Florida International University.

Converting to ICD-10: Challenges and Impacts

This presentation covers the following topics:

- The background of ICD-9 and ICD-10 codes and why a change to ICD-10 is needed.
- The increased complexity of ICD-10 codes that provide more clinical descriptiveness but also mean more work for physicians and medical staff.
- An overview of the changes that the transition to ICD-10 will cause for health care organizations large and small.
- The internal and external costs that will accompany the transition to ICD-10:
  - Costs of increased documentation, providing training and purchasing technology for a provider.
  - Costs of claim denials by health plans due to incomplete documentation or inadequate mapping between code sets.

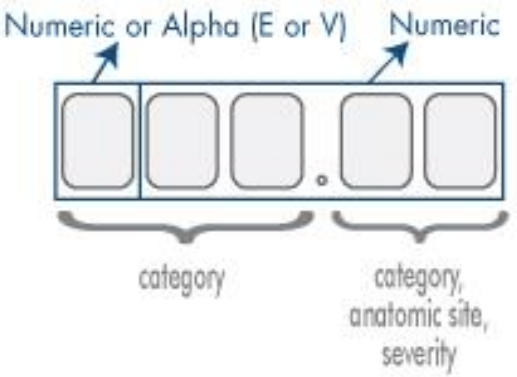
History of ICD-9-CM

The World Health Organization (WHO) developed ICD-9 for use worldwide.

- The U.S. developed the clinical modification (ICD-9-CM) in 1979 by:
  - Expanding the existing number of diagnosis codes.
  - Developing the procedures coding system (CPT).
- **ICD-9-CM Diagnosis codes** are used by all providers to describe diagnoses and procedures in both an inpatient setting (in the hospital) and in an ambulatory setting (the physician practice).
- **ICD-9-PCS Procedure codes** are used by inpatient hospitals to report clinical procedures.
- **Current Procedural Terminology** (CPT-4) is used for reporting ambulatory procedures.

Structure of ICD-9 Codes

ICD-9-CM codes are 3 to 5 digits. The first digit is either numeric or alpha (the letters E or V only) and all other digits are numeric.



HYPERTENSION, HYPERTENSIVE

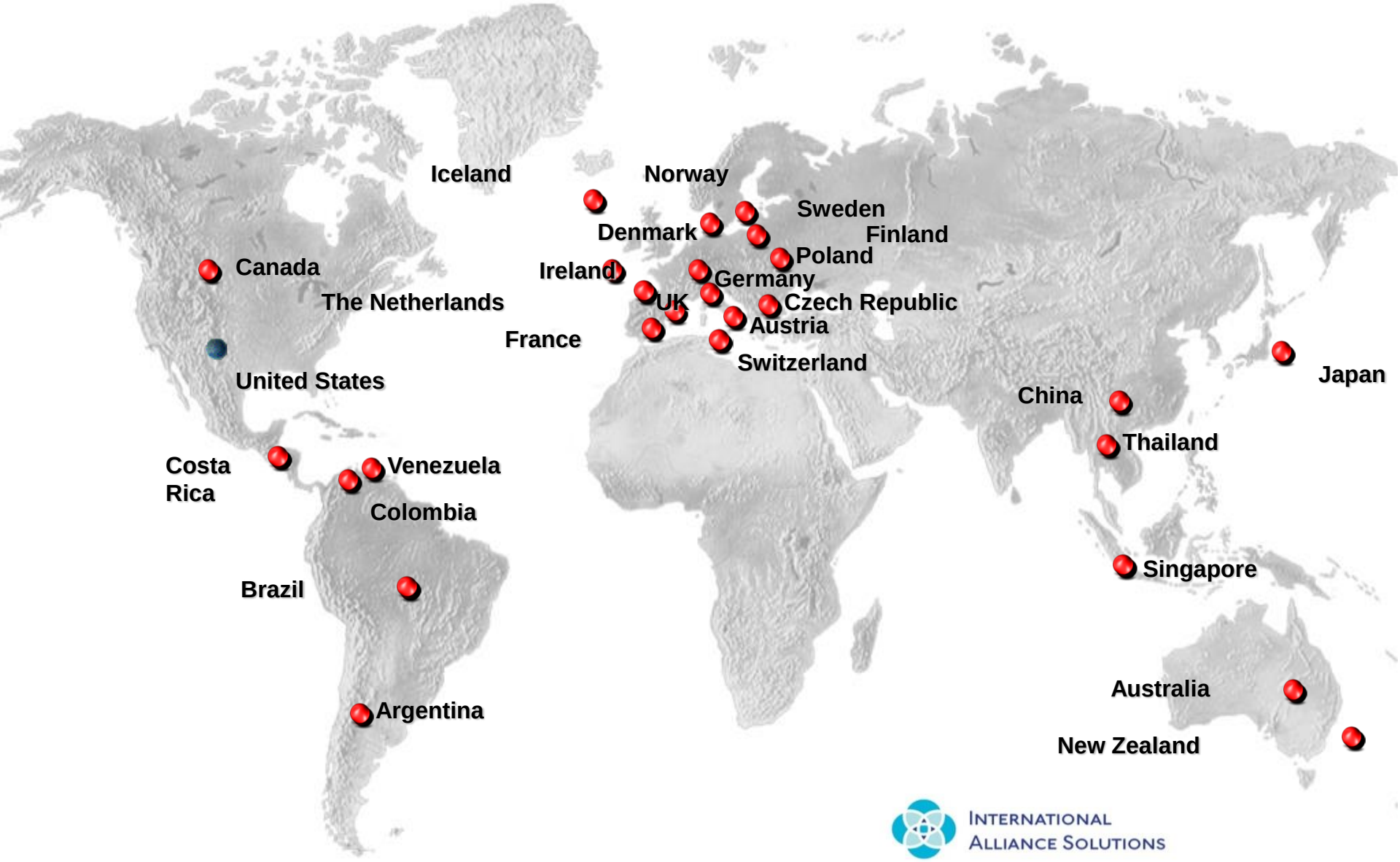
	Malignant	Benign	Unspecified
Hypertension, hypertensive (arterial) (arteriolar) (crisis) (degeneration) (disease) (essential) (fluctuating) (idiopathic) (intermittent) (labile) (low renin) (orthostatic) (paroxysmal) (primary) (systemic) (uncontrolled) (vascular)	401.0	401.1	401.9
with chronic kidney disease stage 1 through stage IV, or unspecified	403.00	403.10	403.90
stage V or end stage renal disease	403.01	403.11	403.91
heart involvement (conditions classifiable to 429.0=429.3, 429.8, 429.9 due to hypertension) (*see also* Hypertension, heart) with kidney involvement —see Hypertension, cardiorenal	402.00	402.10	402.90
renal (kidney) involvement (only conditions classifiable to 585, 587) (excludes conditions classifiable to 485) (*see also* Hypertension, kidney)	403.00	403.10	403.90

Why Upgrade to ICD-10?

The ICD-9 system is over 30 years old and no longer descriptive enough to match current health care needs.

- More precision is needed to identify diagnoses and procedures accurately. For example:
  - A patient fractures his left ankle and a month later, fractures his right ankle. ICD-9-CM does not identify left versus right, so requires additional documentation
- More flexibility is needed to incorporate emerging diagnoses and procedures. For example:
  - When ordering a defibrillator pacemaker, the codes for this device are not in the cardiovascular section of ICD-9-CM with other similar devices.
- Changing to ICD-10 aligns the USA with the coding used by every other developed country in the world.

ICD-10 Implementation – Why Now?

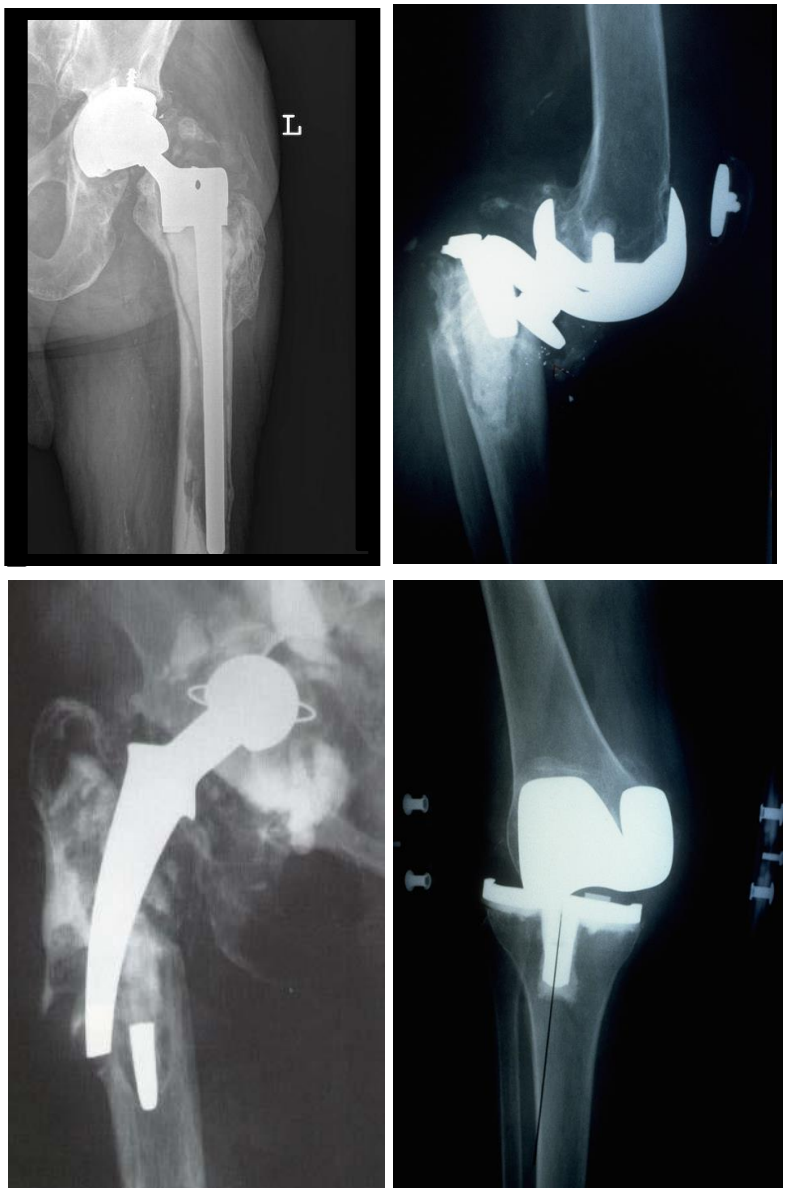


INTERNATIONAL ALLIANCE SOLUTIONS

One Problem with Current ICD-9-CM Codes

Total joint replacement (TJR) is one of the most commonly performed and successful operations in orthopedics today.

- Despite the success achieved with most primary TJR operations, there is a steady increase in the number of failed TJR's, due to:
  - Implant longevity
  - A younger, more active patient population



One Problem with Current ICD-9-CM Codes

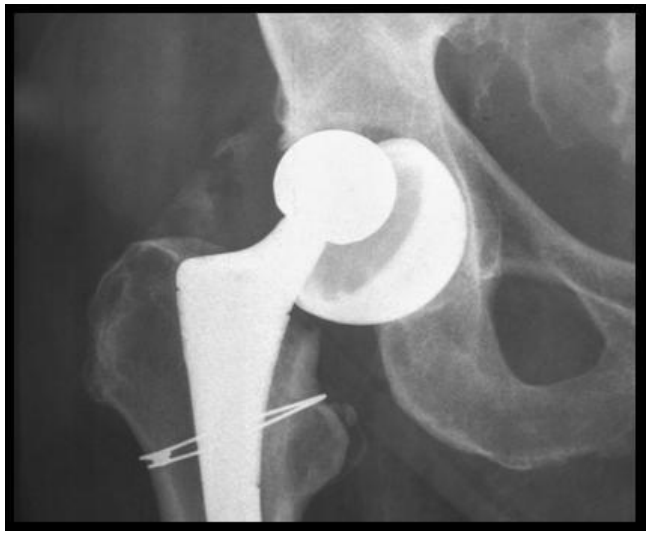
Currently, all failed TJR's are coded as either:

- **<u>996.4</u>** Mechanical complication of an internal orthopedic device, implant, or graft, or
- Mechanical complications involving external fixation device using internal screw(s), pin(s), or other methods of fixation.
- **<u>996.6</u>** Infection and inflammatory reaction due to internal joint prosthesis.

One Problem with Current ICD-9-CM Codes

New technologies and surgical techniques are constantly being introduced into the marketplace.

- Despite careful laboratory testing, a certain percentage of new technologies are associated with higher rates of clinical failure.
- Current ICD-9-CM codes limit the ability to track clinical outcomes and complications related to new techniques and technologies in Total Joint Replacement.



Modes of Failure in Revision Hip and Knee Replacement
Kevin J. Bozic, MD, MBA and Harry E. Rubash, MD
www.cdc.gov/nchs/ppt/icd9/att_TJR_oct04.ppt

What Is ICD-10?

- ICD-10 is the updated version of codes used for coding:
  - Diagnoses for all providers (ICD-10-CM).
  - Inpatient hospital procedures (ICD-10-PCS).
- ICD-10-CM is the US “clinical modification” of the World Health Organization ICD-10 code set.
- ICD-10-PCS is a U.S. creation.
- ICD-10 allows for much greater specificity of care.
  - Full description and consistency within the code set.
  - Uses modern terminology for descriptions.
  - Creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition.

The ICD-10 Regulation

Final ICD-10 regulation was published on January 16, 2009 in the HIPAA Regulations (45 CFR 162.1002).

- The compliance date for using ICD-10-CM for diagnoses and ICD-10-PCS for inpatient hospital procedure codes was originally set for Oct 1, 2013.
  - This was changed to **Oct. 1, 2014** after much protest.
- All covered entities are subject to that date and there is no "transition" time.
  - Services prior to Oct 1, 2014 **must** be coded with ICD-9 codes.
  - Services on and after Oct 1, 2014 **must** be coded with ICD-10 codes.
  - Transactions for service prior to Oct 1, 2014 will continue to be sent or received for some time after conversion.

Changing from ICD-9 to ICD-10

ICD-10 codes are markedly different from ICD-9 coding with attendant far-reaching implications for health care.

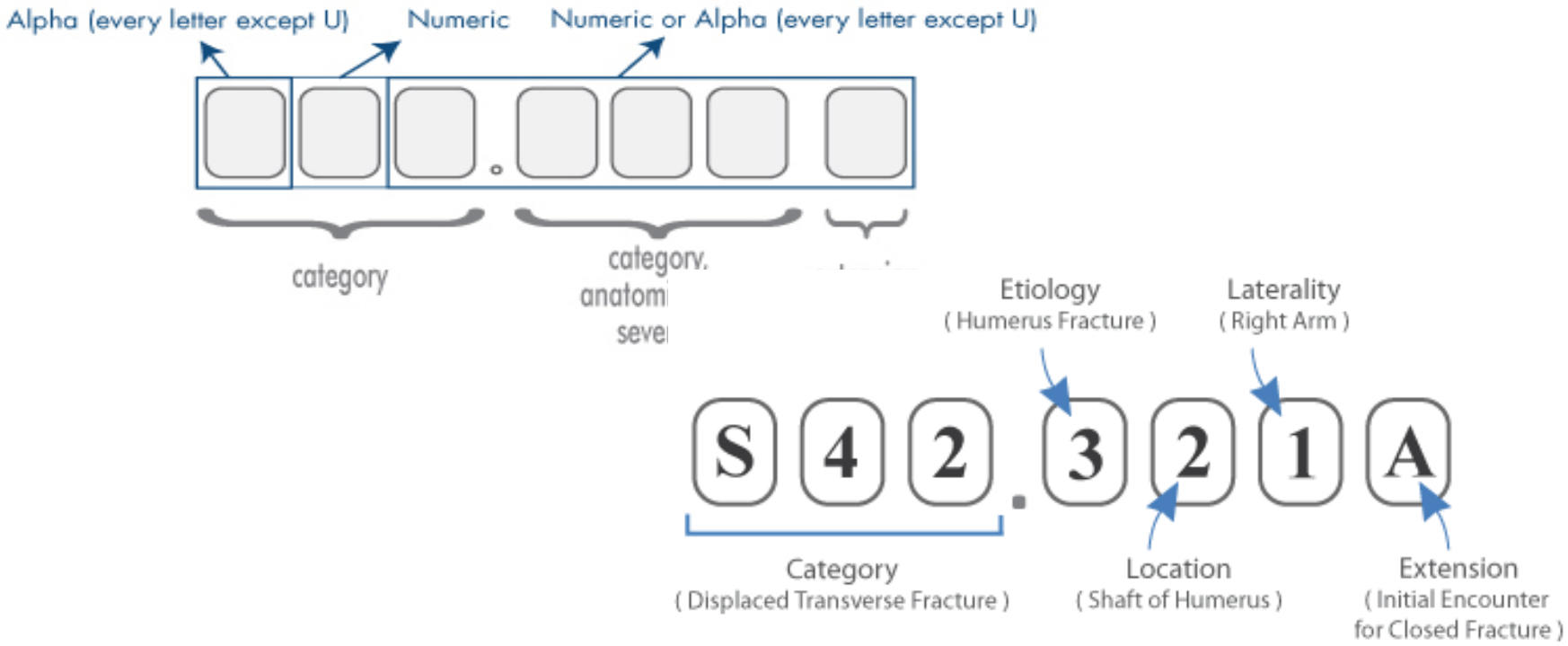
- Requires changes to almost all clinical and administrative systems.
- Requires changes to business processes.
- Results in changes to reimbursement and coverage.

ICD-10 coding allows better diagnosis identification to:

- Track the severity of disease and measure progress.
- Identify disease groupings that merit special attention.
- Ensure effective coverage and payment determination.
- Improve performance monitoring and increased capacity to report quality measures.

ICD-10 Overview: Structure Changes

ICD-10-CM codes can be up to seven digits. The first digit is always alpha (it can be any letter except U), the second digit is always numeric, and the remaining five digits can be any combination.



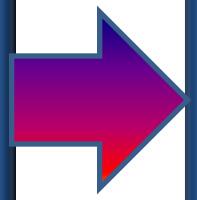
ICD-10 Codes Increase Dramatically Over ICD-9

ICD-9	ICD-10
ICD-9 CM: • 3-5-character alpha-numeric diagnosis codes • Total of **14,025 codes** • 855 code categories.	**ICD-10 CM:** • 3-7-character alphanumeric diagnosis codes • Total of **68,069 codes** • 2,033 code categories.
ICD-9 PCS: • 3-4-character numeric procedure codes • Total of **3,824 codes**	**ICD-10 PCS:** • 7-character alphanumeric procedure codes. • Total of **72,589 codes**

Converting from ICD-9 to ICD-10 Looks Like This

ICD-9-CM

821.01 Fracture of femur, shaft, closed



ICD-10-CM

S72301A Unspecified fracture of shaft of right femur, initial encounter for closed fracture	S72322A Displaced transverse fracture of shaft of left femur, initial encounter for closed fracture	S72326A Nondisplaced transverse fracture of shaft of unspecified femur, initial encounter for closed fracture
S72301G Unspecified fracture of shaft of right femur, subsequent encounter for closed fracture with delayed healing	S72322G Displaced transverse fracture of shaft of left femur, subsequent encounter for closed fracture with delayed healing	S72326G Nondisplaced transverse fracture of shaft of unspecified femur, subsequent encounter for closed fracture with delayed healing
S72302A Unspecified fracture of shaft of left femur, initial encounter for closed fracture	S72323A Displaced transverse fracture of shaft of unspecified femur, initial encounter for closed fracture	S72331A Displaced oblique fracture of shaft of right femur, initial encounter for closed fracture
S72302G Unspecified fracture of shaft of left femur, subsequent encounter for closed fracture with delayed healing	S72323G Displaced transverse fracture of shaft of unspecified femur, subsequent encounter for closed fracture with delayed healing	S72331G Displaced oblique fracture of shaft of right femur, subsequent encounter for closed fracture with delayed healing
S72309A Unspecified fracture of shaft of unspecified femur, initial encounter for closed fracture	S72324A Nondisplaced transverse fracture of shaft of right femur, initial encounter for closed fracture	S72332A Displaced oblique fracture of shaft of left femur, initial encounter for closed fracture
S72309G Unspecified fracture of shaft of unspecified femur, subsequent encounter for closed fracture with delayed healing	S72324G Nondisplaced transverse fracture of shaft of right femur, subsequent encounter for closed fracture with delayed healing	S72332G Displaced oblique fracture of shaft of left femur, subsequent encounter for closed fracture with delayed healing
S72321A Displaced transverse fracture of shaft of right femur, initial encounter for closed fracture	S72325A Nondisplaced transverse fracture of shaft of left femur, initial encounter for closed fracture	S72333A Displaced oblique fracture of shaft of unspecified femur, initial encounter for closed fracture
S72321G Displaced transverse fracture of shaft of right femur, subsequent encounter for closed fracture with delayed healing	S72325G Nondisplaced transverse fracture of shaft of left femur, subsequent encounter for closed fracture with delayed healing	S72333G Displaced oblique fracture of shaft of unspecified femur, subsequent encounter for closed fracture with delayed healing

Many possible codes

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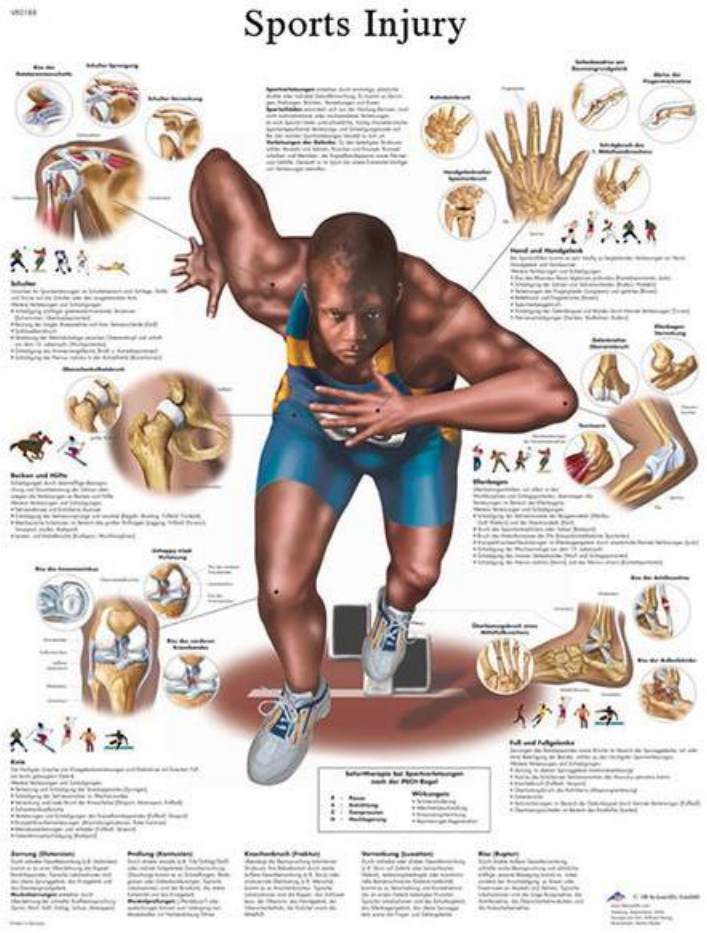
Examples of ICD-10-CM Specificity

Sports injuries are now coded with the sport and the reason for injury

- ICD-9 code - Striking against or struck accidentally in sports without subsequent fall (E917.0)
- There are now 24 ICD-10-CM Detail Codes

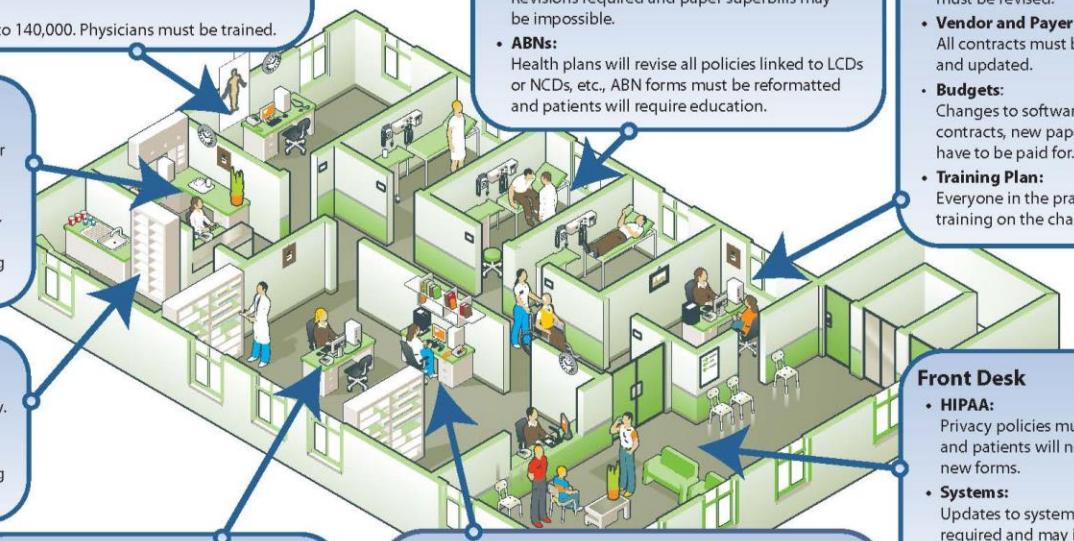


Sports Injury Specificity in ICD-10

- W21.00 Struck by hit or thrown ball, unspecified type
- W21.01 Struck by football
- W21.02 Struck by soccer ball
- W21.03 Struck by baseball
- W21.04 Struck by golf ball
- W21.05 Struck by basketball
- W21.06 Struck by volleyball
- W21.07 Struck by softball
- W21.09 Struck by other hit or thrown ball
- W21.11 Struck by baseball bat
- W21.12 Struck by tennis racquet
- W21.13 Struck by golf club
- W21.19 Struck by other bat, racquet or club
- W21.210 Struck by ice hockey stick
- W21.211 Struck by field hockey stick
- W21.220 Struck by ice hockey puck
- W21.221 Struck by field hockey puck
- W21.31 Struck by shoe cleats Stepped on by shoe cleats
- W21.32 Struck by skate blades
- Skated over by skate blades
- W21.39 Struck by other sports foot wear
- W21.4 Striking against diving board
- W21.81 Striking against or struck by football helmet
- W21.89 Striking against or struck by other sports equipment
- W21.9 Striking against or struck by unspecified sports equipment

Changes Will Be Coming with ICD-10

ICD-10 will change everything.



Physicians
- **Documentation:** The need for specificity dramatically increases by requiring laterality, stages of healing, weeks in pregnancy, episodes of care, and much more.
- **Code Training:** Codes increase from 17,000 to 140,000. Physicians must be trained.

Nurses
- **Forms:** Every order must be revised or recreated.
- **Documentation:** Must use increased specificity.
- **Prior Authorizations:** Policies may change, requiring training and updates.

Lab
- **Documentation:** Must use increased specificity.
- **Reporting:** Health plans will have new requirements for the ordering and reporting of services.

Billing
- **Policies and Procedures:** All payer reimbursement policies may be revised.
- **Training:** Billing department must be trained on new policies and procedures and the ICD-10-CM code set.

Coding
- **Code Set:** Codes will increase from 17,000 to 140,000. As a result, code books and styles will completely change.
- **Clinical Knowledge:** More detailed knowledge of anatomy and medical terminology will be required with increased specificity and more codes.
- **Concurrent Use:** Coders may need to use ICD-9-CM and ICD-10-CM concurrently for a period of time until all claims are resolved.

Clinical Area
- **Patient Coverage:** Health plan policies, payment limitations, and new ABN forms are likely.
- **Superbills:** Revisions required and paper superbills may be impossible.
- **ABNs:** Health plans will revise all policies linked to LCDs or NCDs, etc., ABN forms must be reformatted and patients will require education.

Managers
- **New Policies and Procedures:** Any policy or procedure associated with a diagnosis code, disease management, tracking, or PQRI must be revised.
- **Vendor and Payer Contracts:** All contracts must be evaluated and updated.
- **Budgets:** Changes to software, training, new contracts, new paperwork will have to be paid for.
- **Training Plan:** Everyone in the practice will need training on the changes.

Front Desk
- **HIPAA:** Privacy policies must be revised and patients will need to sign the new forms.
- **Systems:** Updates to systems are likely required and may impact patient encounters.

Will you be ready?

AAPC can help every aspect of your practice's transition to ICD-10. Whether you just want the basics or need complete implementation training, AAPC has a solution to fit your needs.

For more information, visit www.AAPC.com/ICD-10

AAPC
Credentialing the Business Side of Medicine

What Do ICD-10 Changes Mean for Providers?

CMS and some payers expect delayed payments during and after the ICD-10 transition, due to:

- Insufficient documentation for patient care.
- Coding errors due to unfamiliarity with ICD-10.
- Increased payer scrutiny of documentation.

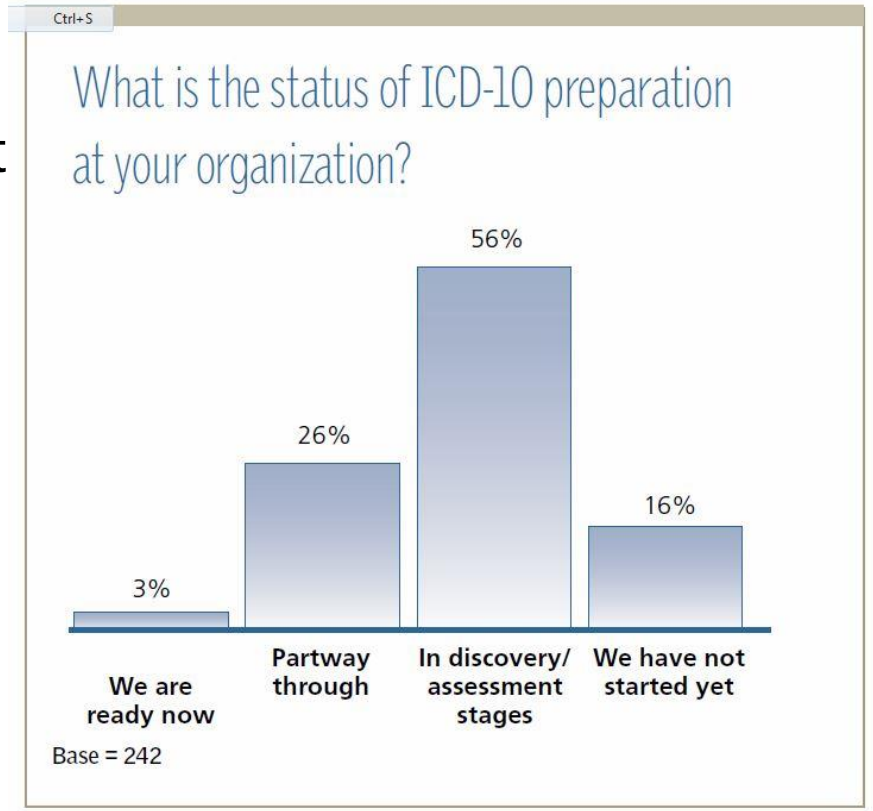
According to the Workgroup for Electronic Data Interchange, account receivable days may increase by 20% - 40% percent after converting to ICD-10.

- For example, say a hospital averages $450,000 net revenue per day with 50 days in A/R.
- The transition from ICD-9 to ICD-10 can cause a 30% delay in A/R to 65 days.
- Hospital will accumulate a delay in receivables of $6.75 million (Revenue per day x increase in A/R days).

The Cost of Not Preparing for ICD-10

There are both internal and external determinants on the cost of transitioning to ICD-10. The most internal important determinant is the cost of not preparing for ICD-10.

- A 2011 survey of ICD-10 readiness by the Health Leaders Media Intelligence Unit found that only 3% of its respondents were ready for the transition.
- A DecisionHealth *2013 National Physician Practice ICD-10 Readiness Survey* found that 22.4% of medical practices don't expect to be ready for the Oct, 1, 2014, deadline.



The Cost of Documentation Under ICD-10

A major challenge of ICD-10 is the detail required in providers' documentation. Physicians won't change how they care for their patients, but they will have to change how they document that care.

- The current coding sets and Revenue Cycle Management process make little use of clinical documentation.
  - The modifications required in clinical documentation represent a challenge to physicians who do not like to document and who delegate coding to support staff.
  - The level of detail required by ICD-10 makes it very difficult to determine the correct coding after the fact.
  - Physicians may now use superbills that are one or two pages in length, but the number of pages will multiply.

How Complex Can Documentation Become?

Date of service:			Account #:		Previous balance:	
Patient name:			Insurance:		Today's charges:	
Address:					Today's payment:	
			Physician name:		Balance due:	
Phone:			NPI#			
DOB:	Age:	Sex:	Tax ID#			

RANK	Office visit	New	Est	RANK	Office procedures		RANK	Laboratory	
	Minimal		99211		Anoscopy	46600		Venipuncture	36415
	Problem focused	99201	99212		Audiometry	92551		Blood glucose, monitoring device	82962
	Exp problem focused	99202	99213		Cerumen removal	69210		Blood glucose, visual dipstick	82948
	Detailed	99203	99214		Colposcopy	57452		CBC, w/ auto, differential	85025
	Comp (established pt)	99204	99215		Colposcopy w/biopsy	57455		CBC, w/o auto	85027
	Comp (new pt)	99205			ECG, w/interpretation	93000		Cholesterol	82465
	Significant, sep serv	-25	-25		ECG, rhythm strip	93040		Hemoccult, guaiac, non-Medicare	82270
	Well visit	**New**	**Est**		Endometrial biopsy	58100		Hemoccult, immunoassay, non-Medicare	82274
	< 1 y	99381	99391		Flexible sigmoidoscopy	45330		Hemoglobin A1C	83036
	1-4 y	99382	99392		Flexible sigmoidoscopy w/biopsy	45331		Lipid panel	80061
	5-11 y	99383	99393		Fracture care, cast/splint	29___		Liver panel	80076
	12-17 y	99384	99394		Site: _____			KOH prep (skin, hair, nails)	87220
	18-39 y	99385	99395		Nebulizer	94640		Metabolic panel, basic	80048
	40-64 y	99386	99396		Nebulizer demo	94664		Metabolic panel, comprehensive	80053
	65 y +	99387	99397		Spirometry	94010		Mononucleosis	86308
	Medicare preventive services				Spirometry, pre and post	94060		Pregnancy, blood	84703
	Annual wellness visit, initial		G0438		Tympanometry	92567		Pregnancy, urine	81025
	Annual wellness visit, subseque		G0439		Vasectomy	55250		Renal panel	80069
	Pap		Q0091		**Skin procedures**	**Units**		Sedimentation rate	85651
	Pelvic & breast		G0101		Burn care, initial	16000		Strep, rapid, antibody	86403
	Prostate/PSA		G0103		Foreign body, skin, simple	10120		Strep culture	87081
	Tobacco counseling/3-10 min		G0436		Foreign body, skin, complex	10121		Strep A, rapid, direct observation	87880
	Tobacco counseling/>10 min		G0437		I&D, abscess	10060		TB	86580
	Welcome to Medicare exam		G0402		I&D, hematoma/seroma	10140		UA, complete, non-automated	81000
	ECG w/Welcome to Medicare		G0403		Laceration repair, simple	120__		UA, w/o micro, non-automated	81002
	Flexible sigmoidoscopy		G0104		Site: _____ Size: _____			UA, w/o micro, automated	81003

S: Mrs. Finley presents today (?) **after having a new cabinet fall on her last week**, suffering a concussion, as well as some cervicalgia. (?) **She was cooking dinner at the home she shares with her husband.** (?) **She did not seek treatment at that time.** She states that the people that put in the cabinet (?) **in her kitchen** missed the stud by about two inches. (?) **Her husband, who was home with her at the time told her she was "out cold" for about two minutes.** The patient continues to have cephalgias since it happened, primarily occipital, extending up into the bilateral occipital and parietal regions. (?) **The headaches come on suddenly, last for long periods of time, and occur every day. They are not relieved by Advil.** She denies any vision changes, any taste changes, any smell changes. The patient has a marked amount of tenderness across the superior trapezius.

O: Her weight is 188 which is up 5 pounds from last time, blood pressure 144/82, pulse rate 70, respirations are 18. She has full strength in her upper extremities. DTRs in the biceps and triceps are adequate. Grip strength is adequate. Heart rate is regular and lungs are clear.

A:
1. Status post concussion with (?) **acute** persistent headaches
2. Cervicalgia
3. Cervical somatic dysfunction

P: The plan at this time is to send her for physical therapy, three times a week for four weeks for cervical soft tissue muscle massage, as well as upper dorsal. We'll recheck her in one month, sooner if needed.

ICD-10-CM Coding:	
S06.0x1A	Concussion with loss of consciousness of 30 minutes or less, initial encounter
G44.311	Acute post traumatic headache, intractable
M54.2	Cervicalgia
M99.01	Segmental and somatic dysfunction of cervical region
W20.8xxA	Struck by falling object (accidentally), initial encounter
Y93.g3	Activity, cooking and baking
Y92.010	Place of occurrence, house, single family, kitchen

ICD-10 Lessons From Canada

A study in Canada during its transition to ICD-10 compared the number of charts completed per hour before and after the transition to ICD-10 in 2002.

- The time to document charts increased because coders had to look for more information in the patient record.

International Alliance Solutions	ICD-10 CA/CCI April 2002	ICD-10 CA/CCI July 2002	ICD-10 CA/CCI April 2003
Inpatient	4.62	2.15	3.75
Same Day Surgery	10.68	3.82	8.53
Emergency Department	10.37	6.49	8.83

The Cost of Documentation Under ICD-10

The level of detail available in ICD-10 places new emphasis on the capture of clinical documentation and will require the use of an EMR.

- The transition to ICD-10 will require providers to describe patient conditions in a new way.
- Providers will have to refer to new coding guidelines.
- Providers will have adhere to new documentation guidelines for the purpose of reimbursements.
- ICD-10 classifies clinical conditions and procedures differently than ICD-9-CM, so:
  - Converting complex payment methodologies between ICD-9 and ICD-10 could have an impact on claims payments to providers.

Costs to Providers Due to DRG Mapping

Disruption in payments to providers may arise due to backward mapping from ICD-10 to ICD-9 Diagnosis Related Groups.

- ICD-9 procedure codes are routinely incorporated in established Diagnosis Related Groups (DRGs).
- With the transformation to ICD-10 two procedure codes may be appropriate but neither will translate to the same DRG as in ICD-9.
- Payers may map the ICD-10 codes received from a claim to ICD-9 in order to use existing ICD-9-based systems without any modifications.
- This could creates provider reimbursement and payment implications, especially in high-cost clinical areas.

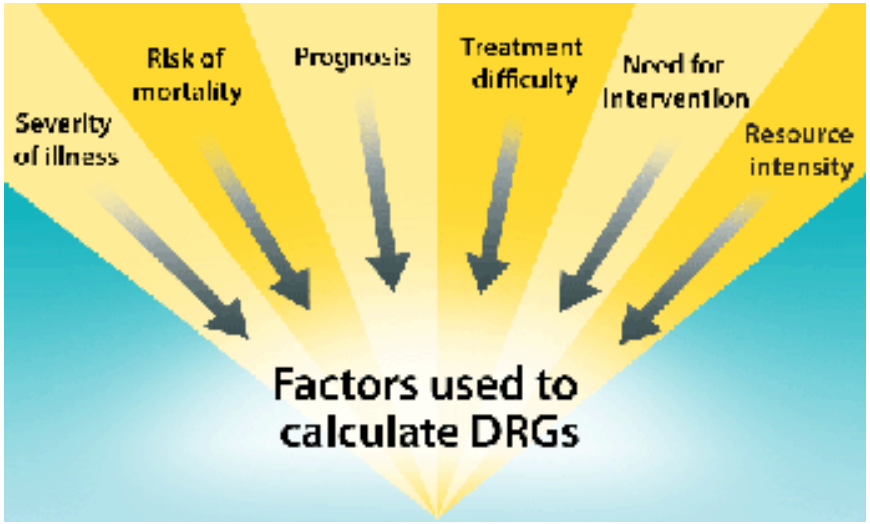
Why the DRG Process is So Important

DRGs classify all human diseases according to the affected organ system, surgical procedures performed on patients, morbidity, and sex of the patient.

- The DRG accounts for the primary diagnosis plus eight additional diagnoses and up to six procedures performed on a patient during his or her clinical encounter.
- The DRG process begins with the physician documenting the patient's principal diagnosis and other factors affecting care or treatment.
- This information is submitted to the medical records department where a medical record coder assigns ICD-9 diagnostic and procedures codes to the encounter.
- The provider then sends the data electronically to its fiscal intermediary on a claim form.

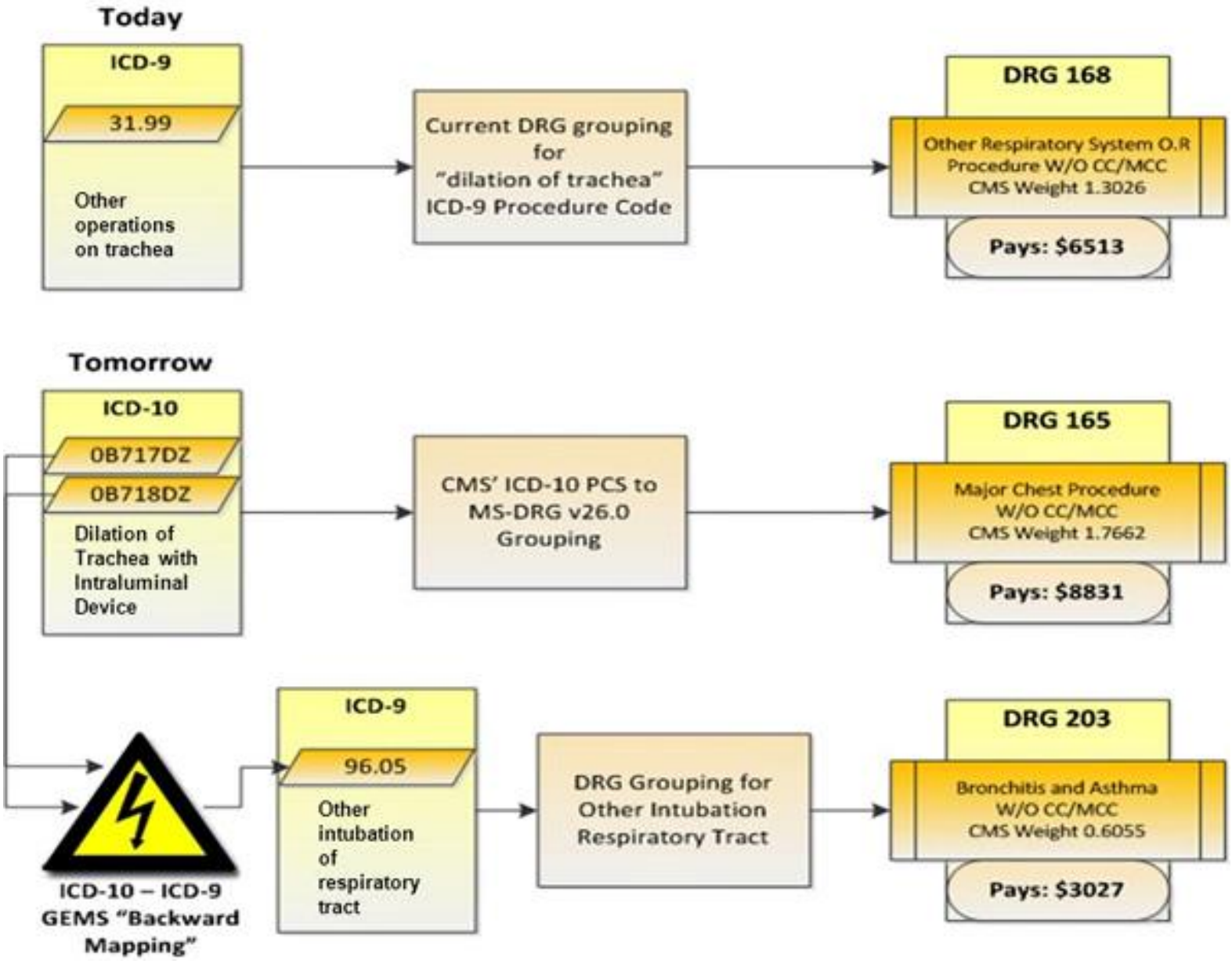
Why the DRG Process is So Important

- The fiscal intermediary inputs these data into its claims processing system and uses an automated algorithm called a "Grouper."
- The program then groups all discharge cases into one of 25 Major Diagnostic Categories before assigning it to one of the 499 DRGs.



- The fiscal intermediary electronically submits the data file to CMS containing all the charge data that has been assigned to each DRG.
- CMS assigns a unique weight to each DRG and calculates a standardized charge for reimbursement.

Costs to Providers Due to DRG Mapping



Training Costs of Transitioning to ICD-10

Training is essential to get the entire provider organization ready for ICD-10. For example:

- Physicians have to get used to including more specific information in their charts.
- Coders and billers have to learn details of anatomy and physiology they didn’t need to know before.

Training also needs to address:

- Executive Management
- Clinicians/Nurses/Case Managers
- Admitting and Scheduling Staff
- Patient Access/Administrative Staff
- Financial Services

Training Costs of Transitioning to ICD-10

The American Health Information Management Association (AHIMA) recommends different levels of training:

- IT staff, directors, and executives can be introduced to ICD-10 through a seven hour program.
- Coding staff need at least 60 hours of extensive training in order to reach proficiency.
  - At least four hours of practice per course should be allotted, with specialty providers focusing on their areas of care.
  - Coders need a mastery level of surgical approach, tools and techniques, procedure purposes, standardized procedural definitions.
  - Coders must know of etiology, disease characteristics, signs/symptoms, manifestations, stages and progression, sequelae, prognosis, related conditions and complications.

Why Training in ICD-10 Is Important

Understanding how ICD-10 codes align with existing ICD-9 contracts and reimbursements data is critical to billing and coordination of benefits. CMS estimates ICD-10 will initially result in a decrease in cash flow and loss of revenue.

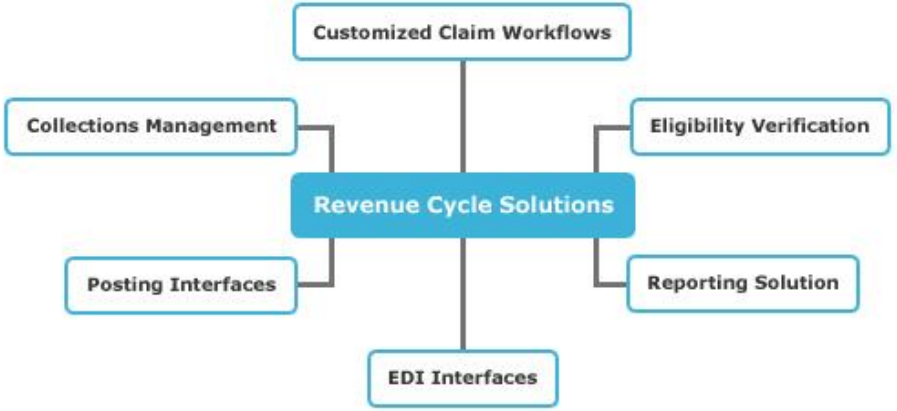
- Providers could see an increased number of denials due to incongruities between the two coding systems.
- Denial rates are expected to increase by 100% – 200% after transitioning to ICD-10.
- Denials could stem from improper eligibility checks or insufficient documentation for processing a claim.
- Healthcare organizations may endure declining payments for up to two years after the October 1, 2014 implementation date

Mitigating ICD-10 Impact with Technology

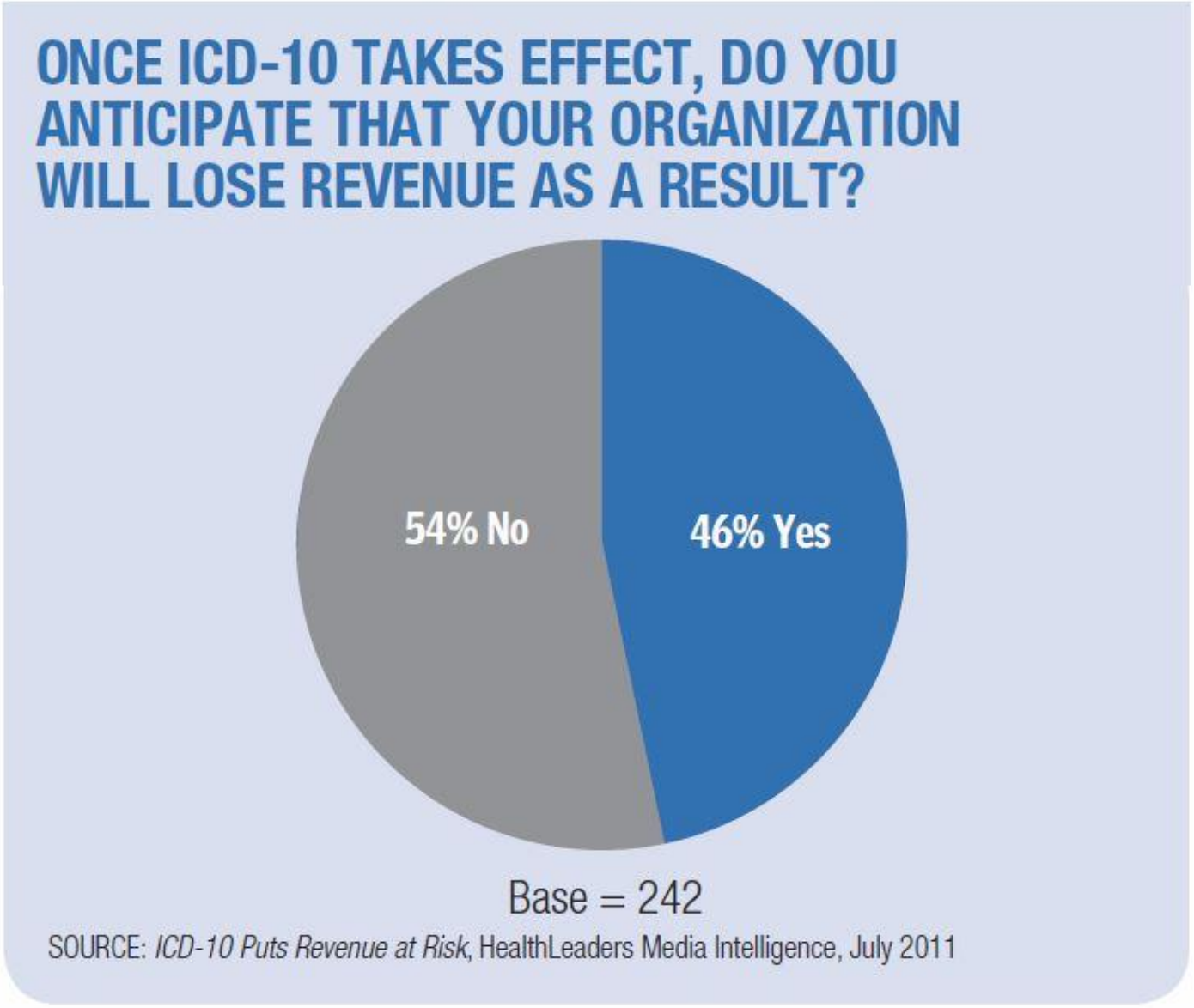
The transition to ICD-10 is forcing providers to implement technology solutions.

- The level of detail available in ICD-10 codes makes the use of an electronic health record system (EHR) a key technology to record clinical documentation.
- New payment models and regulations are forcing hospitals to redirect their budgets to prioritize new RCM solutions that can rescue them from hospital layoffs.

- Most hospital CFOs have no choice but to purchase next generation RCM solutions in order to meet ICD-10 reimbursement challenges ahead.



Impact of ICD-10 on a Provider's Revenue Cycle



Cash Preparedness in Planning for ICD-10

Healthcare providers may face disruptions in their payments even if they have planned their transition to ICD-10.

- The Health Information Management Systems Society (HIMSS) ICD-10 PlayBook recommends providers have at least **six months of cash reserves** to cover medical supplies, payroll, rent and other costs to keep the practice operational following the transition to ICD-10.

"The better way to look at this is that the amount of money that you need to set aside is inversely proportional to the preparation work you do for ICD-10."

– Paul Weygandt, vice president of physician services at J.A. Thomas & Associates

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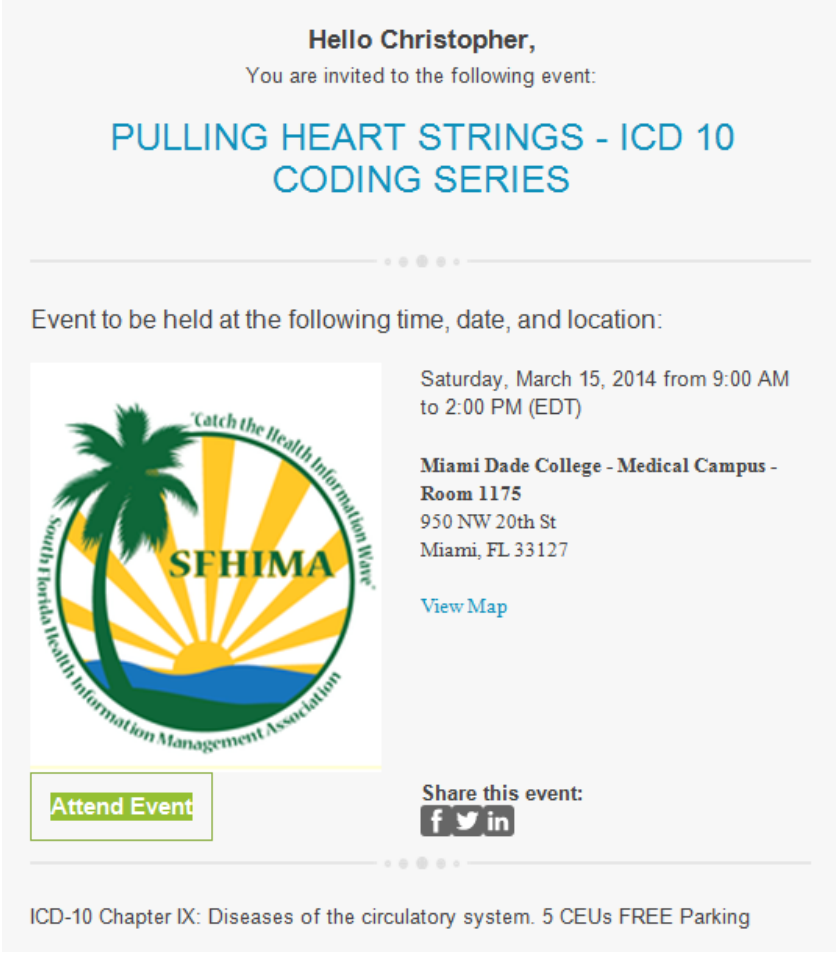
Final Comments

The transition to ICD-10 could be very difficult for many physicians – probably your own family practitioner or local hospital will feel the pain of change this fall.



Hello Christopher,

You are invited to the following event:

PULLING HEART STRINGS - ICD 10 CODING SERIES

Event to be held at the following time, date, and location:

Saturday, March 15, 2014 from 9:00 AM to 2:00 PM (EDT)

Miami Dade College - Medical Campus - Room 1175
950 NW 20th St
Miami, FL 33127

View Map

Attend Event

Share this event:

ICD-10 Chapter IX: Diseases of the circulatory system. 5 CEUs FREE Parking

- It's better for providers to talk with their bankers now before operating funds are needed later this year.
- You can reach out to the providers you work with and help them plan for the coming financial storm of ICD-10.
- Help is still available.

Questions?

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