



Impact of ICD Code Transition



The U.S. Department of Health and Human Services has mandated the transition from the medical coding standard ICD-9 (International Classification of Diseases, 9th Revision) to ICD-10 by October 1, 2013. This transition will require monumental business and systems changes throughout the healthcare industry for all parties covered by the Health Insurance Portability and Accountability Act (HIPAA).

ICD-10 is intended to address medical coding with greater precision than ICD-9, evidenced by the fact that the number of codes has grown approximately tenfold (with approximately 155,000 ICD-10 codes). Current approaches to achieving ICD-10 compliance require significant investments estimated to be \$2-\$3 billion industry wide, including updating and integrating IT systems, developing documentation, and training personnel.

- Current solutions for matching ICD-10 codes to electronic medical records (EMR) prove to be a significant manual task for coders, administrators, and medical personnel in all health provider organizations.
- There is an acute need for solutions that enable healthcare providers to increase the efficiency and accuracy of their coding process to save time, streamline resources, and optimize billing returns.
- xPatterns Computer-Assisted Coding alleviates the financial and compliance burden of transitioning to ICD-10.

The xPatterns Difference

xPatterns Computer-Assisted Coding (C.A.C.) provides a breakthrough decision support solution, streamlining the billing and compliance process with highly accurate results. Healthcare providers benefit by quickly and accurately determining the best ICD-9 and ICD-10 diagnostic and procedure codes to lower administrative costs and increasing billing efficiency.

Benefits of xPatterns Computer-Assisted Coding

- Improve accuracy of coding services.
 - Increase the number of codes generated per hour.
 - Decrease rejected claims with better clinical documentation.
 - Receive corresponding ICD-9 and ICD-10 codes in a dual view application.
 - ICD-10 training tool for coders, administrators, and medical personnel.
- xPatterns C.A.C. ingests a portion or entire patient EMR (as a large unstructured query) via a voice or text file.
 - Automatically discovers relevant concepts, relationships, and patterns in the EMR.
 - Surfaces the top five most accurate ICD-9 and ICD-10 procedure and diagnostic codes applicable to the record. (A dual view of both code sets is a valuable training tool).
 - Result set of codes are ordered for optimal billing results and can be integrated with a billing system, exported to a flat file, or administrative database.
 - Dynamically learns and further refines accuracy with user interaction.



Clinical Support Documentation

Challenges with ICD-10 Codes

- **Revenue Loss:** miscoding and under-coding with current systems, using traditional “decision-tree” solutions.
- **Education Requirements:** training medical personnel, coders, and administrators in highly complex code classifications.
- **IT Limitations:** inability of current systems to automatically convert ICD-9 codes to ICD-10 codes.

xPatterns C.A.C. also streamlines the education and compliance process with clinical support documentation:

- Access each specific text description within an EMR that generated an ICD code.
- Archive administrative user activity for training and audit support purposes.

Deploy xPatterns Computer-Assisted Coding

xPatterns C.A.C. can be deployed as Software-as-a-service (SaaS), with no financial barrier to entry for healthcare providers and clients to secure their data within your current environment.

EMR

PHYSICAL EXAM: The patient is a 40-year-old white male.

General: The patient is moderately obese but he is otherwise healthy. He has moderate discomfort but there is no evidence of distress or respiratory abnormality or difficulty.

HEENT: Normocephalic/atraumatic head. Pupils are 2.5 mm bilaterally. Extraocular muscles are intact bilaterally. External auditory canals are clear and intact bilaterally.

Neck: No JVD. Neck is supple. There is free range of motion. No lymphadenopathy noted.

Pharynx: Clear. **DIAGNOSTIC STUDIES:** tonsillar enlargement.

LABORATORY:

1. CBC: WBC 14.2, hematocrit 33.5, platelets 816
2. Chem 7: Na 142, potassium 4.5, chloride 102, creatinine 1.2
3. Serum Troponin I: 2.5
4. Chest x-ray: Lung fields clear. No cardiomegaly.

PROCEDURES:

1. 10:40 PM Dr. ABC (cardiology) performed a 66-lead ambulatory rhythm strip. He is to come see patient in the emergency department.

TREATMENT:

1. Heparin lock X, Z.
2. Nasal cannula oxygen 3 liters/minute.
3. Aspirin 5 grains chew & swallow.
4. Nitroglycerin drip at 30 micrograms/minute.
5. Cardiac monitor.
6. TPA 90 minute protocol.



