ICD-10 . . . Ready or Not?

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Speaker

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• She is a member of the editorial advisory board for Briefings on Coding Compliance Strategies. In April 2006, she provided testimony in support of ICD-10 implementation for the House Ways and Means Committee, and in 2007 she was awarded the AHIMA Triumph “Champion” award.

• She is the Past-President of the California Health Information Association, the 2015 receipt of the “Industry Champion Award” and Chair of ICD-10 Advocacy Taskforce.
Disclaimer

• This material is designed and provided to communicate information about ICD-10 Revenue Cycle, clinical documentation, coding, and compliance in an educational format and manner.

• The author is not providing or offering legal advice but, rather, practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding.

• Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful.

• Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation.

Comments and opinions of the Speaker as not those of Kaiser Permanente.

Goals/Objectives

• Brief ICD-10 Background & Review
• Learn about ICD-10 code set impact
• Final Readiness Plans
• Post Go-Live Steps and Planning
• Questions/Answers
30 DAYS AND COUNTING!
But how many “working days at
there?" 

• The transition to ICD-10 is occurring because
  ICD-9 produces limited data about patients’
  medical conditions and hospital inpatient
  procedures. ICD-9 is 30 years old, has outdated
terms, and is inconsistent with current medical
practice.
• Also, the structure of ICD-9 limits the number of
  new codes that can be created, and many ICD-9
categories are full.

Background & History: In the Beginning...

• Intent and evolvement since 1938 BUT dating back to the
  early 1900’s...
• ICD has codes only for diagnoses and external causes of
  injuries
• Statistical tool for international exchange of mortality data
• Expanded to collect morbidity data while patients are still
  alive
• ICD-9-CM revised into a 9th revision in 1975
• ICD-9-CM’s lack of numbers to address global emergency
History/Background

- The International Classification of Diseases (ICD) is the standard diagnostic classification tool for epidemiology, health management and clinical purposes.
- The design of the classification system was to have updates every 10 years, due to changes in medicine and medical technologies.
- ICD-9 code set has been in use in the United States since 1979 with annual revisions.
- ICD-10 came into use in World Health Organization (WHO) in 1994

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History/Background

- ICD-10-CM is the United States’ clinical modification of the World Health Organization’s ICD-10. The term “clinical” is used to emphasize the modification’s intent: to serve as a useful tool in the area of classification of morbidity data for indexing of health records, medical care review, and ambulatory and other health care programs, as well as for basic health statistics.
- To describe the clinical picture of the patient the codes must be more precise than those needed only for statistical groupings and trend analysis.
History/Background

• Since ICD-10 will affect nearly all areas of your practice, hospital and organization, project teams should consist of representatives from key areas of your organization, including:
  - Senior Management
  - Health Information Management/Coding
  - Patient Access
  - Billing/Finance
  - Compliance
  - Revenue Cycle Management
  - Information Systems and Technology

• This multi-disciplinary team provides the cooperative environment necessary to address your organization's needs.

History/Background:
Benefits of ICD-10

• More Specific Coding / More Accurate Reimbursement
• Faster Reimbursement / Fewer Denials (Long-Term)
• Able to Accommodate Treatments Post-ICD-9
• Better EMR Support
• Improved Safety, Medical Management and Quality of Care
• Improved Portfolio Management
• Redesign Clinical and Administrative Operations
• Enhance Integration with Payers and Providers

Source: Accenture: “Preparing Payers for ICD-10”
New Features to ICD-10-CM

- Combination codes for conditions and common symptoms or manifestations
  - E10.21 Type 1 diabetes mellitus with diabetic nephropathy
- Combination codes for poisonings and external causes
  - T42.4x5A Adverse effect of benzodiazepines, initial encounter
- Added laterality (left vs. right)
  - M94.211 Chondromalacia, right shoulder
- Added 7th character extensions for episode of care
  - S06.01x A Concussion with loss of consciousness of 30 minutes or less, initial encounter
- Expanded codes (injuries, diabetes, alcohol/substance abuse, postoperative complications)
  - F14.221 Cocaine dependence with intoxication delirium

New to ICD-10-CM...

- Injuries are grouped by anatomic site rather than by type of injury.
- Diseases of the sense organs (eyes & ears) have their own chapters, no longer part of Nervous System chapter.
- Inclusion of trimesters in obstetric codes (and elimination of 5th digits for episode of care)
  - O99.013 Anemia complicating pregnancy, third trimester
- Change in timeframes specified in certain codes
  - Acute myocardial infarction – time period changed from 8 weeks to 4 weeks
- Full code titles for ALL codes (no reference back to common fourth and fifth digits).
- Post-op complications have been moved to procedure-specific body system chapters.
ICD-10-CM Features

1) Laterality (Left, Right, Bilateral)
   - Examples:
     - C50.511 – Malignant neoplasm of lower-outer quadrant of right female breast;
     - H16.013 – Central corneal ulcer, bilateral; and
     - L89.012 – Pressure ulcer of right elbow, stage II.

2) Combination Codes For Certain Conditions and Common Associated Symptoms and Manifestations
   - Examples:
     - K57.21 – Diverticulitis of large intestine with perforation and abscess with bleeding;
     - E11.341 – Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema; and
     - I25.110 – Atherosclerotic heart disease of native coronary artery with unstable angina pectoris.

3) Combination Codes for Poisonings and Their Associated External Cause
   - Example:
     - T42.3x2S – Poisoning by barbiturates, intentional self-harm, sequela.

4) Obstetric Codes Identify Trimester Instead of Episode of Care
   - Example:
     - O26.02 – Excessive weight gain in pregnancy, second trimester

Key Implementation Areas

- ICD-10 represents the broadest scope of any
- ICD revision to date. WEDI report in 2000 said it was “most significant overhaul of the medical coding system since the advent of computers.”
  - Payers
  - Providers, Pharmacies, Laboratories
  - Researchers
  - Vendors
  - Clearinghouses / TPA’s
  - Employers, Members/Subscribers
  - Suppliers
  - Other Business Partners
  - Accreditation Entities -- JCAHO, NCQA
Areas of Impact …

- Software / Packages
- Reimbursement / Contracting
- Procedures / Care Management Policies
- Education/ Training
- Forms
- Statistics / Reporting / Research
- Billing & Transactions
- Patient Access/Registration
- Transition to Golive and After
- Other?

Systems Ready?

- System upgrades implemented to achieve ICD-10 compliance (an electronic health record and other critical applications that use diagnosis codes or descriptions)
- Maintain a testing environment prior to going live
- ICD-10-compliant versions of software are running smoothly
- Changes to format, logic, business rules
  - Screens, DB’s, Files, Reports, Queries, Edits, Mapping
  - Adjudication, Reimbursement, Other Logic
  - Authorization, Actuarial, Case Management/UM
  - Customer and Other External Reporting, Data Warehouses
- Changes to purchased software
  - Groupers, Edits, Statistics, Reference
Systems and IT

- Schedule software/hardware testing.
- Updating and testing
- Review internal policies
- Core Measure software readiness
- Disease Mgmt. programs/software
- SOFTWARE
  - Scheduling
  - Billing
  - Claims Submission
  - Finance / Performance
  - Intensive Care / ER Activity

Vendor Software

- Update software (same types of changes as described earlier)
  - Decision Support Systems
  - Billing / Practice Management
  - Clinical
  - Managed Care / HEDIS, Other Quality Reporting
- Update Documentation
- Negotiate with Supported Sites
- Install / Convert / Train
What about testing?

• CMS recommends that you contact your software vendors and begin testing!
• Participate in CMS testing?
  • Though it is a good idea to begin testing as soon as possible, the reality is that testing requires other parties (vendors) to also be ready to “receive” test transactions and generate feedback.
• Work closely with your clearinghouses to implement testing.
• Also work with your payers so you can begin testing on your claims.

Systems and Applications: Consider the readiness

<table>
<thead>
<tr>
<th>FIGURE 2. Examples of Systems and Applications That May Use Coded Data</th>
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</thead>
<tbody>
<tr>
<td>Encoding software</td>
<td>Case mix systems</td>
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<tr>
<td>Medical record abstracting systems</td>
<td>Managed care reporting systems</td>
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<td>Billing systems</td>
<td>Case management systems</td>
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<tr>
<td>DRG groups</td>
<td>Disease management systems</td>
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<td>Electronic health record systems</td>
<td>Financial systems</td>
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<td>Clinical systems</td>
<td>Provider profiling systems</td>
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<td>Decision support systems</td>
<td>Test ordering systems</td>
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<td>Computer-assisted coding applications</td>
<td>Clinical reminder systems</td>
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<tr>
<td>Registration and scheduling</td>
<td>Performance measure systems</td>
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<tr>
<td>Utilization management</td>
<td>Medical necessity software</td>
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<td>Quality management</td>
<td>Aggregate data reporting systems</td>
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<td>Computerized physician order entry systems</td>
<td>Registries</td>
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<tr>
<td>Clinical protocols</td>
<td>Compliance software</td>
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<tr>
<td>Fraud management systems</td>
<td>Patient assessment data sets (e.g., MDS, PA, OASIS)</td>
</tr>
</tbody>
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Source AHIMA
Data Users: Consider the Impact

FIGURE 3. Examples of Categories of Data Users Requiring ICD-10 Education

<table>
<thead>
<tr>
<th>Category</th>
<th>Training Needs</th>
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</thead>
<tbody>
<tr>
<td>Coders</td>
<td>Clinical department managers</td>
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<tr>
<td>Other HIM staff</td>
<td>Ancillary departments</td>
</tr>
<tr>
<td>Clinicians</td>
<td>Data analysts</td>
</tr>
<tr>
<td>Senior management</td>
<td>Researchers</td>
</tr>
<tr>
<td>IT staff</td>
<td>Epidemiologists</td>
</tr>
<tr>
<td>Quality management</td>
<td>Performance improvement</td>
</tr>
<tr>
<td>Utilization management</td>
<td>Corporate compliance</td>
</tr>
<tr>
<td>Accounting</td>
<td>Data quality management</td>
</tr>
<tr>
<td>Business office</td>
<td>Data security</td>
</tr>
<tr>
<td>Auditors and consultants</td>
<td>Clinical documentation improvement staff</td>
</tr>
<tr>
<td>Patient access and registration</td>
<td>Payer contract managers and negotiators</td>
</tr>
<tr>
<td>Other data users</td>
<td>Registry personnel</td>
</tr>
</tbody>
</table>

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Policy/Procedure Checklist: Readiness

This tool can help you validate your compliance review and updating of coding policies/procedure, memo’s, etc. Target a completion date.

ICD-10 Coding Policy & Procedure Checklist
Payers

- The following are some questions to ask your payers about their reimbursement under ICD-10:
  - Will you be changing your benefit coverage based on diagnosis codes?
  - How will you process “unspecified” codes?
  - When will your updated policies be available for us to access?

LCDs

- Each Medicare Administrative Contractor (MAC) releases a “local coverage determination” (or LCD) for each specialty
- LCDs likely are going to be the first place to look for acceptable ICD-10 codes
- Find LCDs is to use the Medicare Coverage Database, which can be found online at [http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx#HowToUseThisSite](http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx#HowToUseThisSite) (simply select your state and type/specialty)
LCDs (con’t)

• According to MLN Matters Document No. MM8348 (see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8348.pdf), all LCDs with ICD-10 codes must be available in the Medicare Coverage Database by April 10, 2014.

Cash Flow Slow Downs...

• Financial contingency plan for post October 1, 2015.
• Have a line of working credit available in the case of short term delays in billing and collection
• Some tips and areas to consider include, but may not be limited to:
  • Focus on expenses
    • Renegotiate terms with major suppliers to create a more balanced payment schedule over time
    • Identify and implement other cost saving measures in advance of October 2015
    • Aggressively manage inventory levels to avoid expensive overstock costs
    • Reduce other administrative overhead where possible
ICD-10 Cash flow tips

• Focus on receivables:
  • Manage your Accounts Receivable (AR) aging aggressively, minimize charge-offs and denied payments
  • If you have not already done so, consult with your banker about adopting best practices, procedures, and products that will enable you to collect patient co-pays or deductibles at the time of patient encounter
  • Work all denials and rejects aggressively to eliminate their occurrence and ensure more first time third party payer payments

(Source: Well Fargo Treasury Mgmt.)

Anticipating reimbursement changes

• Number of pended claims for additional information related to diagnosis
• Number of denied claims related to diagnosis coding
• Average reimbursement for specific priority services performed
• Overall account receivables
• Number of other transactions (eligibility, prior authorization) that include diagnosis codes pended for additional information related to diagnosis
• Number of other transactions (eligibility, prior authorization) that include diagnosis codes denied related to diagnosis code
• Number of requests for additional information to support transactions (claims, prior authorization)
Reimbursement Changes?

- One way to make sure your organization doesn’t lose money after the transition is to have an external chart reviewer analyze your documentation and coding process now to determine what changes you need to make to work better with ICD-10.
- Select for review 100-200 charts that represent a large proportion of your patient volume, ones that are for higher-dollar charges, and ones that are at higher risk of being denied.
- MS-DRG Shifts

Eligibility Inquiry and Response

- Most payers support eligibility inquiry benefit requests based on Service Type Codes.
- In the eligibility transaction, ICD-10 content is present only when it is required to be relevant to the inquiry.
- The ICD data usually is not required in the eligibility request and responses.
Medical Necessity product within Patient Access Services

• Medical Necessity products that contain both current ICD-9 and new ICD-10 edits should be available.
  • Check and confirm
• Medical Necessity will use date of service and the ICD-10 compliance date to determine the appropriate edits to query.
  • Users of Medical Necessity validation should be oriented to the new code set
    • Coding Resource should be made available for questions

Scheduling and Registration Processes: Questions to Ask . . .

• Is your facility prepared for patients who present to your centralized registration department or serving department with a script for outpatient services that contain an ICD-9 CM code?
• What is your current process for scripts containing no codes but only a written description of the code?
• Does your registration staff perform any coding assignments today? If so, have they been incorporated into your ICD-10 CM training program?
• Is the staff in the registration areas certified in coding or do they have access to certified coders?
• Are you prepared to update codes for services that are scheduled prior to October 1st, with an actual service date after the coding change takes effect?
• Are your centralized scheduling department and/or ancillary department resources prepared to schedule patients’ with an outdated code?
Scheduling and Registration

- Determine how patients are scheduled and registered for outpatient services.
- Focus on the scheduling and registration areas to determine how the initial diagnosis code is entered into the health information system.
- Identify how medical necessity is monitored, as well as, the process for obtaining authorizations and referrals.
- Document the current steps (workflow) for each area, along with the specific resource(s) responsible for selecting or providing an ICD-9 CM diagnosis or procedure codes. Include task responsibilities of everyone, including the ordering physicians.
- COMMUNICATE!

Scheduling and Registration

- Communicate expectations with your physician groups.
- Discuss the requirements for patients to have accurate and complete scripts and referrals/authorizations.
- Review the need for quick response times when the information is not complete and the patient is at the hospital check-in area.
- Develop a revenue cycle task team to include resources from patient access, patient accounting, ancillary departments and physician groups.
- Hold scheduled meetings to discuss issues pertaining to the implementation of ICD-10 CM.
- Work together as a team
Things to Do in August

• Coding Tips
  • Create and disseminate
• Documentation Tips
  • Create and disseminate
• Dual Coding
  • ICD-9 & ICD-10
  • System acceptance
• “Practice” Coding 7-10 hrs in month
• Check data reporting (decision support) systems
• Catchup on Backlog coding work
• Hold “Change Mgmt” in-service for all effective staff

• Physician documentation awareness
• Physician Queries – new language
• CDI
• Patient Access discuss and review plan
• IT final testing
• External providers readiness
• Physician offices ready

Things to Do in September

• Catchup on Backlog coding work
• Coding Tips
  • Create and disseminate
• Documentation Tips
  • Create and disseminate
• Dual Coding
• “Practice” Coding 8-10 hrs in month
• Coding encoder/software tools used/tested
• Final “Refresher” Coding Training
  • 2 to 3 hrs
• Pre-Go-Live calls: last week of September

• Patient Access readiness review and discussion
• Plan for Patient Questions
• Plan for MD questions
• PFS systems readiness, final test
• PFS “cut-over” accounts readiness (9/30 to 10/1)
• Denial Mgmt. team
  • ICD-10 preparations
• Payer system readiness, final test/checks
• EHR readiness
• Hold “Change Mgmt” in-service for all effective staff
Remember...

- Best practices are constantly evolving and no list is ever truly complete.

Go-Live: Command Center

- Establish an 800 # for regular call-in
  - Designate a HOST
- Start the week prior to 10/1
  - Sept
  - October 2-3 weeks
- Operational Group Call: IT, Revenue Cycle, Compliance, Clinical Operations
- Patient Call Center
  - Claim questions
- Patient Access
  - Questions
- Gather information and share
- Planning for corrective plan and timeline
- External Provider Questions

- Business line calls: HIM Coding
  - Types of issues (and successes)
    - Coding
      - ICD-10-CM or PCS
      - Alpha or tabular
      - Convention or guideline
  - Documentation
  - Diagnosis or procedure
    - Track specialty or MD Dept.
  - Systems/IT
    - Encoder; EHR; finance; registration
Go-Live: October 2015

- Establish a “Command Center”
  - Daily the first 2 weeks at a minimum
  - Call center
- Track and Trend “issues”, problems and concerns (report)
- Areas:
  - Systems
  - Communication
  - HIM Coding
  - Physician and other Clinicians
- Types:
  - IT, Coding, Billing, Patient Access, etc.
- Degree of impact or severity: score
  - Red
  - Yellow
  - Green
- Remediation/Correction Plans

Plan your first 2 weeks

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Develop a plan for coverage
Post Go-Live... Lots to Do!

- Denials Management
  - Claim reviews
  - Claim correction & resubmission
- Patient Communications
- Coding Quality Assessment
- Ongoing Education/Training
- Physician documentation awareness and education

Final Readiness Plans

- Command Center
- Communications
- Tracking and Trending
- Check and Recheck
- Resolutions and Problem Solving
- Contingency plans
Post Go-Live Steps and Planning

- Auditing and Reviews
- Re-Education
- Patient Financial Services (PFS)
- Denial Management
- System/IT

Worth it ... More Codes Mean Better Analysis

- Richer set of data for practice analysis.
- Use your electronic medical record solution, ICD-10 should enable improved outcomes analysis that will help enhance your quality of care.
- The new ICD-10 codes combined with patient financial data will better prepare your practice to demonstrate physician quality reporting systems (PQRS) and address other pay-for performance programs.
What happens if things go wrong?

• You need contingency planning.
• Backup plans
• Ask .......what if...?

Next Steps . . .

• Go to the CMS website
  • Review the “split Claim guidance”
• Other resources
• Contract coding services: check for available staff
• Look at technology solutions
• Systems readiness
• Documentation and Coding readiness
Summary

- Counting down to 10/1/2014... it’s 2015!
- ICD-10 readiness and plan
- Inclusion of all work areas/streams
- Proactive rather than reactive
- Have a good plan
- Include contingency
- Go-Live and Post Go-Live
- Command Center
- Communications
- Other – solutions and technology
• One thing is certain—ICD-10 will impact nearly everyone in the health care field including: providers, nurses, coders, billers, IT personnel, claims adjudicators, managers, HR personnel, researchers, data managers, auditors, compliance officers, fraud and abuse and investigators.

What is Your Answer to This Question . . . ?
Do you have any Questions?

Thank you!
References/Resources

- EHR Intelligence – July 2013
- CMS.gov
- AHIMA.org
- AAPC.com