ICD-10 STARTS WITH PROVIDERS

Steve Arter, CPC | Managing Member
THANK YOU FOR JOINING US

• WHO IS HERE TODAY

• HEALTHCARE CODING CONSULTANTS OF HAWAII
  • WORKING ON BEHALF OF PHYSICIANS AND PROVIDERS 25 YEARS
  • CODING EDUCATION AND TRAINING IN HAWAII SINCE 1999

• CLINICAL CARE PROVIDERS OF MULTIPLE SPECIALTIES

• HAWAII HEALTH INFORMATION EXCHANGE
PURPOSE:

To enable a successful transition to ICD-10 for providers
TODAYS OBJECTIVES

• That you:

1. Understand what is driving the shift to ICD-10
2. Know the basic differences between ICD-10 and ICD-9
3. Know the mandatory changes for ICD-10
4. Have access to efficient resources and tools to assist you in converting your ICD-9 codes and making the transition to ICD-10
5. Know 3 key steps necessary for a successful transition to ICD-10
WHAT IS ICD-10-CM AND WILL IT HAPPEN?

• ICD-10 is mandated under HIPAA

• The 3rd final rule and delay say October 1, 2015

• You should hope so. ICD-10 is the best thing to happen to Providers in 30 years despite the 70,000 codes

• Given the massive change in Healthcare reimbursement that is taking place ICD-10 is the foundation for accurate reimbursement and data

WHAT CHANGE YOU SAY?
REIMBURSEMENT BASED UPON OUTCOMES ANNOUNCED BY MEDICARE

CMS is striving to build an infrastructure that goes from fee for service to assuming risk.

– Marilyn Tavenner
CMS Administrative Director
December 9, 2014
REIMBURSEMENT BASED UPON QUALITY NOT QUANTITY ANNOUNCED BY MEDICARE

We are moving away from paying per procedure or for volume to paying based upon evidence and quality.

– Marilyn Tavenner
CMS Administrative Director
December 9, 2014
HEALTH AND HUMAN SERVICES SECRETARY
SYLVIA MATHEWS BURWELL

GOALS:

• Tie 30% of Medicare FFS payments to quality or value by 2016; 50% by 2018 through alternative payment arrangements (e.g. ACOs)

• Tie 85% of all traditional Medicare payments (includes PPS payment) to quality or value by 2016; 90% by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs
ENDORSED BY PHYSICIAN ORGANIZATIONS AND HEALTH INSURERS

We're all partners in this effort focused on a shared goal. Ultimately, this is about improving the health of each person by making the best use of our resources for patient good. We're on board, and we're committed to changing how we pay for and deliver care to achieve better health.

– Douglas E. Henley, M.D., EVP
CEO
American Academy of Family Physicians

Advancing a patient-centered health system requires a fundamental transformation in how we pay for and deliver care. Today’s announcement by Secretary Burwell is a major step forward in achieving that goal.

– Karen Ignagni
President + CEO
Americas Health Insurance Plans
Representing 1300 Health Insurers

WHAT IS DRIVING THIS ACCELERATED SHIFT?

The uncontrolled rise in healthcare spending:

$2.6 Trillion (US Healthcare Spending 2013)

• Chronic Care Patients with 4 or More Conditions Account for 74% of all Medicare Spending CMS 2010

• Chronic diseases account for $3 of every $4 spent on healthcare CDC

• Average healthcare costs for someone who has one or more chronic conditions is 5 times greater than for someone without any chronic conditions Partnership For Solutions, Johns Hopkins
THIS IS NOT GOING TO HAPPEN ... IT IS HAPPENING!

• In Hawaii we now have:
  – Medicare Advantage Plans
  – Alohacare, United Health, Ohana
  – HMSA Akamai Advantage, AARP, Humana

• Patient Centered Medical Home
  (Focused on total care management of patients)

• HMSA’s request for input on a new reimbursement model and their new Patient Support Program (PSP)
WHAT DO ALL OF THE BELOW HAVE IN COMMON?

PATIENT CENTERED MEDICAL HOME
EVIDENCE BASED MEDICINE
RISK ADJUSTED REIMBURSEMENT PLANS
ACCOUNTABLE CARE ORGANIZATIONS (ACOs)
HIERARCHICAL CATEGORY CODES
MEDICAL NECESSITY DENIALS
PAY FOR PERFORMANCE/QUALITY MEASUREMENT
PREAUTHORIZATIONS
CHRONIC ILLNESS AND DISABILITY PAYMENT SYSTEM (MEDICAID CPDS)
THEY’RE ALL EXAMPLES OF REIMBURSEMENT MODELS OR ISSUES DRIVEN BY DIAGNOSIS

• We are shifting to a diagnosis driven healthcare paradigm – ICD-10 is required for this

• More and more Providers, hospitals, labs, and clinics are being reimbursed and evaluated based upon the acuity levels of their patients and the outcomes of treatments

• Medical Necessity Denials are the #1 reason claims are rejected other than demographic errors
THEY’RE ALL EXAMPLES OF REIMBURSEMENT MODELS OR ISSUES DRIVEN BY DIAGNOSIS

• Healthcare has been moving toward this since diagnosis codes were first put on HCFA 1500 forms in the early 80’s

• ICD-9 is an inadequate system for determining outcomes or reimbursement (no new codes since 2011)

• ICD-10 is a significant improvement for determining outcomes or reimbursement
WHY ICD-10? WHY 70,000 CODES?

• ICD-9-CM is outdated
  • Over 30 years old
  • Many categories full
  • Unable to precisely identify diagnoses

• Coding system needs to be:
  • Flexible enough to quickly incorporate emerging diagnoses
  • Exact enough to precisely identify diagnoses
  • ICD-10 accomplishes both of these goals

• ICD-11 is 250,000 codes and 7 years away at least
RED DOTS
THE DEMAND FOR REPORTING DIAGNOSES HAS SHIFTED – MORE IS BETTER

- Payers are pushing for increased reporting of diagnoses
- Hierarchical Condition Codes (HCCs)
- Reporting of Chronic Conditions

This is a direct result of the move towards Outcomes Based Reimbursement
THIS REPRESENTS A COMPLETE SHIFT IN WHAT PAYERS HAVE TOLD PROVIDERS FOR YEARS

• Don’t worry about the diagnosis codes
• Just give us 1 to get paid
• We can’t accept more than 4 diagnoses
• We only read the first diagnosis code anyway
WHERE WILL THIS SHIFT IMPACT PROVIDERS

• Fee for Service reimbursement – Immediately

• PCMH models are managing patient populations overall health – based on Diagnosis

• Reimbursement models are shifting to risk adjusted and risk shared reimbursement

• Reimbursement for specialty services are being bundled and analyzed for diagnosis based carve out reimbursement

ALL OF THESE DEPEND ON PROVIDERS’ DOCUMENTATION & REPORTING DIAGNOSES
ICD-10 IS A REQUIREMENT FOR AN E-HEALTH SYSTEM

"ICD-10 … is a cornerstone of several integrated programs that build toward a modernized health care system.

— Marilyn Tavenner
CMS Administrative Director

DOES ANYONE HERE THINK WE ARE GOING BACK TO PAPER?
ICD-10 — IT’S NOT SO DIFFERENT FROM ICD-9... THERE’S JUST MORE TO LOVE
ICD-10-CM CODE STRUCTURE

**ICD-9-CM Code Format**

- **Supervision of Other Normal Pregnancy**
  - ICD-9: V22.1

**ICD-10-CM Code Format**

- **Supervision of normal first pregnancy 1st trimester**
  - ICD-10: Z34.01

**Code Weeks of Gestation and Episode of Care**
THE NEW GUIDELINES TO IMPROVE DATA FOCUS ON MORE SPECIFIC INFORMATION

• OB/GYN – INCLUDE TRIMESTERS AND WEEKS OF GESTATION

• RESPIRATORY CONDITIONS – CODE TOBACCO USE

• ACCIDENTS AND INJURIES – INCLUDE LOCATIONS

• FRACTURES – INCLUDE TYPE OF FRACTURE AND DEGREE OF HEALING
SPECIFICITY IS THE KEY TO BETTER DATA AND

“UNSPECIFIED” MAY LEAD TO “UNPAID”

Providers may be ICD-10 compliant, but if they abuse the “other” or “unspecified” codes, payment will not occur if a more specific alternative exists.

– Dennis Winkler
Director of Technical Program Management
Blue Cross Blue Shield of Michigan

Justifying payment for procedures and services depends on specificity of diagnoses coding!
UNSPECIFIED CODES—TREAD LIGHTLY

- Similar to ICD-9 ... ICD-10 does contain “unspecified” codes

- Coding guidelines advise use of “unspecified” in circumstances where the medical record does not contain sufficient information required to assign a more specific code

- Medicare and local payers seem to have given us time to adjust to the use of more specific codes – 12 Months (see handout from CMS) THIS IS NOT THE CASE!

- It is still in your best interest to code to the greatest specificity as soon as possible
# HAWAII’S HEALTH PLANS

<table>
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<th>Will Accept Unspecified Codes</th>
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<tr>
<td>Aloha Care$^2$</td>
<td></td>
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</tr>
<tr>
<td>HMSA Quest$^2$</td>
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</table>

$^1$You can’t continue to use unspecified codes forever  
$^2$Pending clarification from MedQuest Division
HAVING BETTER DIAGNOSES IS A GOOD THING FOR PATIENTS AND PROVIDERS

- For the first time ever, you will have a tool to communicate how sick your patients really are and a way to justify appropriate reimbursement

- Outcomes can be measured based upon specific categories of diseases and conditions

- Clinical quality of outcomes can be more easily demonstrated – these are tied largely to diagnosis (chronic conditions, comorbidities)
GOOD DIAGNOSIS DATA FROM SPECIFIC ICD-10 CODES WILL BE IMPORTANT TO PROVIDERS

- For the first time ever, you will have the ability to identify which treatment protocols are most effective on specific conditions
- Payers are shifting risk to providers in the new reimbursement models; no authorizations, no payment, no denials
- With risk comes authority to make decisions
- The data from ICD10 will be critical in helping providers to make decisions
THE KEY TO SUCCESS IS THE DOCUMENTATION - NOT THE 70,000 CODES

• THE PRIMARY ROLE OF PROVIDERS

LEARN AND RECORD THE NEW DOCUMENTATION ELEMENTS FOR YOUR REGULARLY UTILIZED DIAGNOSES

DOCUMENT ALL DIAGNOSES THAT WERE A FACTOR IN THE VISIT

Medicare’s guidelines now state, “Code all documented conditions which coexist at the time of the visit that require or impact patient care or treatment”

MEAT – Monitor, Evaluate, Assess, Treat – any of these justify documentation and coding of a condition according to Medicare
HOW CAN I POSSIBLY CONVERT ALL OUR CODES AND KNOW IF THEY MEET THE REQUIREMENTS FOR SPECIFICITY??

- There are tools available to you that allow one person to complete the task in less than a day so that it may be reviewed by the physicians in your practice.


- Specialty societies and your respective specialty colleges have crosswalks available to members for a nominal fee (e.g. aaos.org)

- Medicare makes National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) available for reference on its website.
### Supervision of other normal pregnancy

<table>
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<th>GEMS ICD-10 Description</th>
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</tbody>
</table>

**Additional ICD-10 Description**

- Encounter for supervision of normal first pregnancy, unspecified trimester
- Encounter for supervision of normal first pregnancy, first trimester
- Encounter for supervision of normal first pregnancy, second trimester
- Encounter for supervision of normal first pregnancy, third trimester
- Encounter for supervision of other normal pregnancy, first trimester
- Encounter for supervision of other normal pregnancy, second trimester
- Encounter for supervision of other normal pregnancy, third trimester
- Encounter for supervision of normal pregnancy, unspecified, first trimester
- Encounter for supervision of normal pregnancy, unspecified, second trimester
- Encounter for supervision of normal pregnancy, unspecified, third trimester

**Note:**

- Codes in this category are specific to the trimester of pregnancy. Other trimesters require a different code.
- Additional code from category Z3A, Weeks of gestation, to identify the specific week of the pregnancy when reporting codes from category Z34.
<table>
<thead>
<tr>
<th>ICD-10 Description</th>
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</thead>
<tbody>
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<tr>
<td>Type 2 diabetes mellitus with hyperosmolarity with coma</td>
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<tr>
<td>Type 2 diabetes mellitus with diabetic nephropathy</td>
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<tr>
<td>Type 2 diabetes mellitus with diabetic chronic kidney disease</td>
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<tr>
<td>Type 2 diabetes mellitus with other diabetic kidney complication</td>
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<tr>
<td>Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema</td>
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<tr>
<td>Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema</td>
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<tr>
<td>Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema</td>
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<tr>
<td>Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema</td>
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<tr>
<td>Type 2 diabetes mellitus with diabetic cataract</td>
</tr>
<tr>
<td>Type 2 diabetes mellitus with other diabetic ophthalmic complication</td>
</tr>
<tr>
<td>Type 2 diabetes mellitus with diabetic neuropathy, unspecified</td>
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<tr>
<td>Type 2 diabetes mellitus with diabetic mononeuropathy</td>
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<tr>
<td>Type 2 diabetes mellitus with diabetic polyneuropathy</td>
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</table>
UNDERSTAND MEDICAL NECESSITY FROM A PAYER PERSPECTIVE

- The number one reason claims are denied other than demographics errors is due to a lack of medical necessity.

- In a front end edit lack of medical necessity means the diagnosis does not justify the service provided.

- It may also mean that the wrong code has been used for the procedure or test ordered (e.g., I10 for HBA1C).

- Under ICD-10, a code that lacks specificity may be deemed a lack of medical necessity or simply not specific enough (Medicare).
HOW DO YOU AVOID MEDICAL NECESSITY DENIALS?

After you convert and select your NEW ICD-10 codes for your lab orders compare them to Medicare’s National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) to ensure the tests that you are ordering using your NEW ICD-10 codes are covered codes—NCDs provide Medicare’s determinations of what diagnoses justify service

- This will not completely eliminate denials but it will reduce them and will avoid the large increases predicted

- Most payers have their own policies most of which are similar to or based on Medicare. You should obtain these policies from your largest payers. (pain management)

- They will include frequency limitations and other key issues
Did you know that there are some ICD-10 codes that can never be used to justify medical necessity for a lab test? This single NCD has 10 pages of non-covered diagnoses!
Most NCDs show “ICD-10-CM Codes Covered by Medicare Program” (green arrow) followed by an ICD-10 list of covered codes; but look at the Blood Count NCD... It states “ICD-10-CM Codes That Do Not Support Medical Necessity” (red arrow) followed by a list of ICD-10s. Be careful not to misinterpret these policies when you read them!
THE 3 KEY STEPS TO A SUCCESSFUL ICD-10 IMPLEMENTATION FOR YOUR ORGANIZATION

• CLINICAL DOCUMENTATION IMPROVEMENT

• AN OPERATIONAL CHANGE IMPACT ASSESSMENT OF YOUR ORGANIZATION

• A READINESS ASSESSMENT OF ALL VENDORS, SYSTEMS, AND PAYERS
WHAT TO DO – STEP ONE (PROVIDERS)

• Identify your ICD-9 codes in order of frequency of use

• Convert them to ICD-10 codes

• Identify the new elements of documentation required for specific ICD-10 coding

• Start learning to use the new elements of documentation a few each week
WHAT TO DO – STEP ONE (Providers)

• Low level of effort required with significant returns

• You will begin to build the data of acuity against which your will be measured

• You will be ready for October 1, 2015
WHAT TO DO – STEP TWO (Admin Staff)

• Conduct a clinical impact assessment by:
  – Determining every place an ICD-9 code is used
  – Looking at what changes will be needed to use ICD-10
  – Looking at how processes must change to accommodate ICD-10
  – Determining what training will be needed for which staff members
  – Determining how communication with partners must change (lab orders, imaging, prescriptions)
WHAT TO DO – STEP THREE (Admin Staff)

Evaluate the true readiness of your software systems and payers and what must be done to use them effectively:

- Call your software vendor and ask the hard questions
- Schedule acknowledgement testing with key payers
- Determine what the ICD-10 capabilities of your PM and EHR systems will be

GOOD SOFTWARE WILL MAKE ICD-10 CODING EASIER
A FEW THINGS TO REMEMBER

- We cannot overemphasize this point: Be as specific as you possibly can with diagnoses.
- Where appropriate, include things like laterality, trimester and number of weeks gestation, especially in situations in which a placenta is involved, as a matter of habit.
- Always include LMP information for female patients if available.
- Any standing orders written prior to October 1, 2015, that require specimen collection after ICD-10 implementation must include ICD-9 and ICD-10 codes.
- The same is true for Class 3 Prescriptions, Care Plans, or pre-authorizations that will be post October 1, 2015 that were not sent with an ICD-10 code.
- Always get the referred to physicians final DX code to add to your records with the consult report of findings.
GENTLE REMINDERS

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