ICD-10 STARTS WITH PROVIDERS

Steve Arter, CPC | Managing Member

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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

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PURPOSE:

To enable a successful transition to ICD-10 for providers

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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

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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?

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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

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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

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HEALTH AND HUMAN SERVICES SECRETARY SYLVIA MATHEWS BURWELL

National Press Conference
Jan 26, 2015

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

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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

http://www.hhs.gov/news/press/2015pres/01/20150126a.html

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SYLVIA MATHEWS BURWELL, SECRETARY HHS ESTABLISHED GOALS

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

http://www.hhs.gov/news/press/2015pres/01/20150126a.html

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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

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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)

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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)

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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

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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

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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

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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

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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

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ICD-10 IS A REQUIREMENT FOR AN E-HEALTH SYSTEM

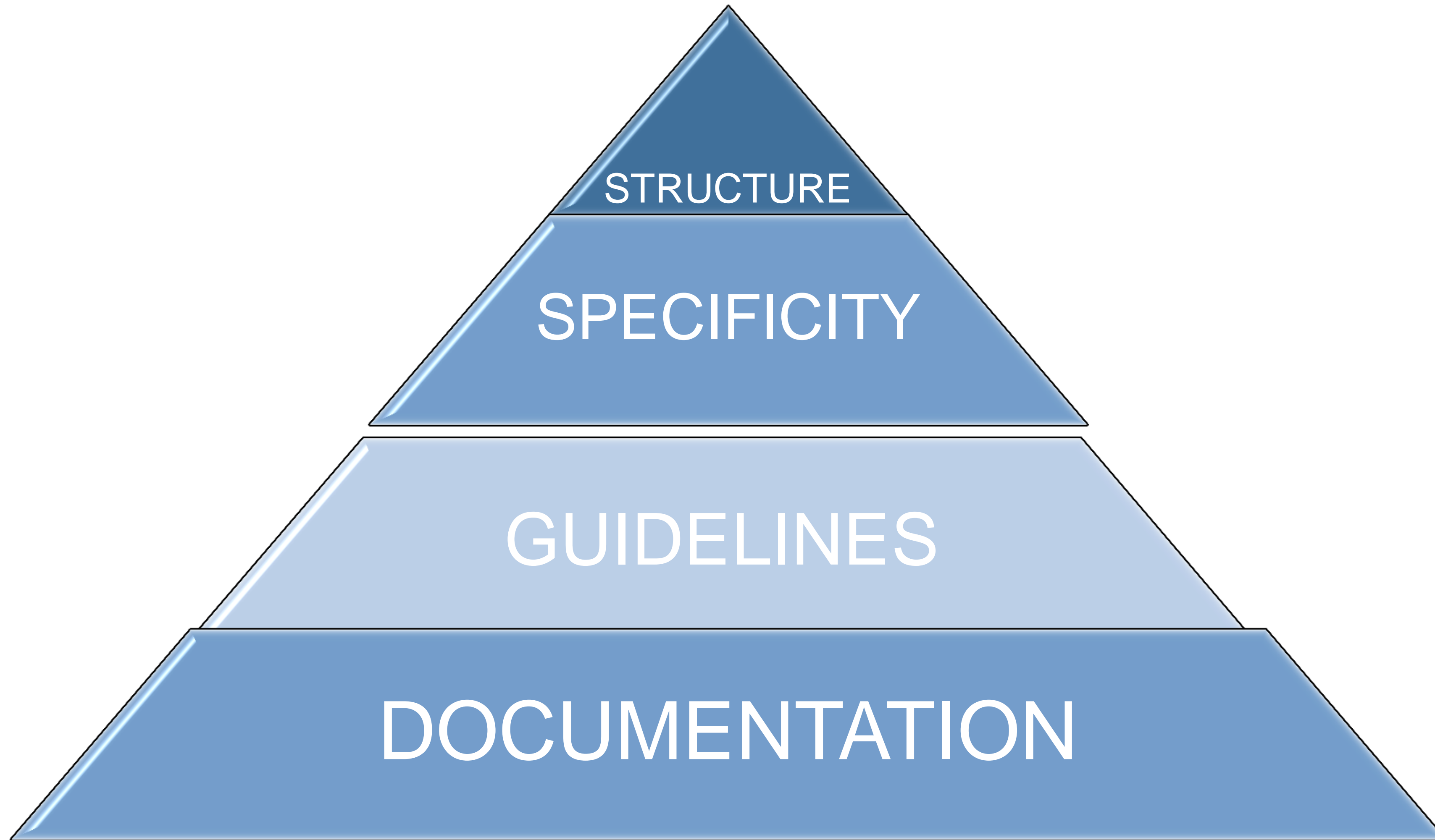
"ICD-10 … is a cornerstone of several integrated programs that build toward a modernized health care system."

— **Marilyn Tavenner**

CMS Administrative Director

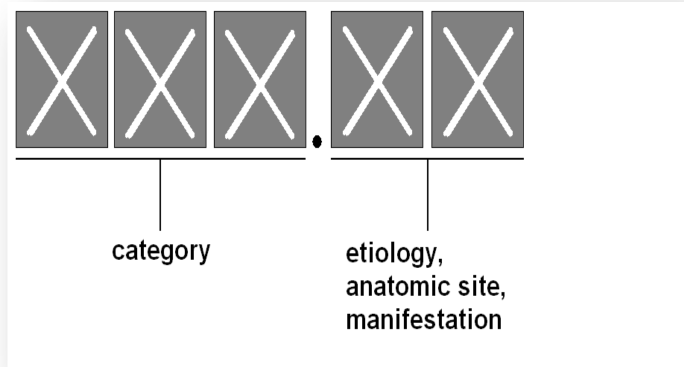
DOES ANYONE HERE THINK WE ARE GOING BACK TO PAPER?

ICD-10 — IT'S NOT SO DIFFERENT FROM ICD-9... THERE'S JUST MORE TO LOVE



ICD-10-CM CODE STRUCTURE

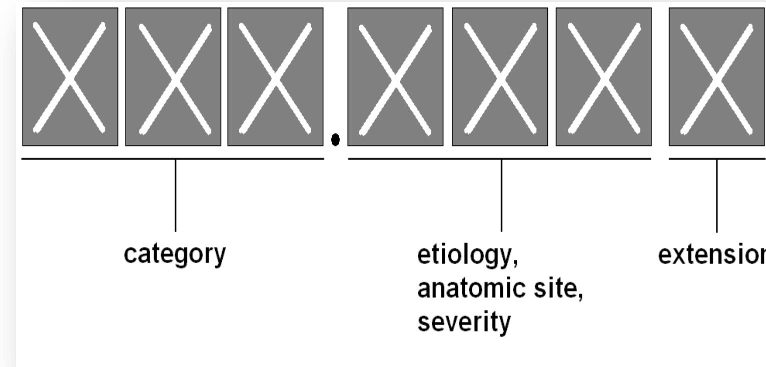
ICD-9-CM Code Format



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

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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

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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!

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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

Health Plan	Will Accept Unspecified Codes	Will Monitor for Inappropriate Use[1]
HMSA	✓	✓
UHA	✓	✓
Aloha Care[2]		✓
HMSA Quest[2]	✓	✓

[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)

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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

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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

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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

  Visit http://hcch.cpticdpros.com Free conversion software

- 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

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	Supervision of other normal pregnancy

le	GEMS ICD-10 Description	Approximate	No Map	Combination	Scenario	Choice List
	Encounter for supervision of other nor	Yes	No	No	0	0
	Encounter for supervision of normal pr	Yes	No	No	0	0

Options	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

r supervision of pregnancy require documentation of trimester
code from category Z3A, Weeks of gestation, to identify the specific week of the pregnancy when reporting codes from category Z34

ICD-9 ICD-10 All Words Clear

ICD-10 Description
Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
Type 2 diabetes mellitus with hyperosmolarity with coma
Type 2 diabetes mellitus with diabetic nephropathy
Type 2 diabetes mellitus with diabetic chronic kidney disease
Type 2 diabetes mellitus with other diabetic kidney complication
Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema
Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema
Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema
Type 2 diabetes mellitus with diabetic cataract
Type 2 diabetes mellitus with other diabetic ophthalmic complication
Type 2 diabetes mellitus with diabetic neuropathy, unspecified
Type 2 diabetes mellitus with diabetic mononeuropathy
Type 2 diabetes mellitus with diabetic polyneuropathy

ICD-9 Conversion List

ICD-10 Conversion List

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)

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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

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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!

Medicare National Coverage Determinations (NCD)
Coding Policy Manual and Change Report
DRAFT ICD-10-CM Version

Non-covered ICD-10-CM Codes for All Lab NCDs

This section lists codes that are never covered by Medicare for a diagnostic lab testing service. If a code from this section is given as the reason for the test, the test may be billed to the Medicare beneficiary without billing Medicare first because the service is not covered by statute, in most instances because it is performed for screening purposes and is not within an exception. The beneficiary, however, does have a right to have the claim submitted to Medicare, upon request.

The ICD-10-CM codes in the table below can be viewed on CMS' website as part of Downloads: Lab Code List, at http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10.html

Code	Description
R99	Ill-defined and unknown cause of mortality
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Encounter for general adult medical examination with abnormal findings
Z00.110	Health examination for newborn under 8 days old
Z00.111	Health examination for newborn 8 to 28 days old
Z00.121	Encounter for routine child health examination with abnormal findings
Z00.129	Encounter for routine child health examination without abnormal findings
Z00.5	Encounter for examination of potential donor of organ and tissue
Z00.6	Encounter for examination for normal comparison and control in clinical research program
Z00.70	Encounter for examination for period of delayed growth in childhood without abnormal findings
Z00.71	Encounter for examination for period of delayed growth in childhood with abnormal findings
Z00.8	Encounter for other general examination
Z02.0	Encounter for examination for admission to educational institution
Z02.1	Encounter for pre-employment examination
Z02.2	Encounter for examination for admission to residential institution
Z02.3	Encounter for examination for recruitment to armed forces
Z02.4	Encounter for examination for driving license

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!

190.20 - Blood Glucose Testing

Description

This policy is intended to apply to blood samples used to determine glucose levels. Blood glucose determination may be done using whole blood, serum or plasma. It may be sampled by capillary puncture, as in the fingerstick method, or by vein puncture or arterial sampling. The method for assay may be by color comparison of an indicator stick, by meter assay of whole blood or a filtrate of whole blood, using a device approved for home monitoring, or by using a laboratory assay system using serum or plasma. The convenience of the meter or stick color method allows a patient to have access to blood glucose values in less than a minute or so and has become a standard of care for control of blood glucose, even in the inpatient setting.

HCPCS Codes (Alphanumeric, CPT® AMA)

Code	Description
82947	Glucose; quantitative, blood (except reagent strip)
82948	Glucose; blood, reagent strip
82962	Glucose, blood by glucose monitoring device cleared by FDA for home use.

ICD-10-CM Codes Covered by Medicare Program

The ICD-10-CM codes in the table below can be viewed on CMS’ website as part of Downloads: Lab Code List, at
http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10.html

Code	Description
A15.0	Tuberculosis of lung
A15.5	Tuberculosis of larynx, trachea and bronchus
A22.1	Pulmonary anthrax
A37.01	Whooping cough due to Bordetella pertussis with pneumonia
A37.11	Whooping cough due to Bordetella parapertussis with pneumonia
A37.81	Whooping cough due to other Bordetella species with pneumonia
A37.91	Whooping cough, unspecified species with pneumonia

190.15 - Blood Counts

alities of the blood
nia, polycythemia,
ffect the blood or
s, neoplasms and
l or bone marrow,

vhite blood count
ells, and platelets,

l are commonly
he blood or bone
abnormalities of
the disease or its
ory tests.

to determine the
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rential WBC count
ifferential WBC

Medicare National Coverage Determinations (NCD)
Coding Policy Manual and Change Report
DRAFT ICD-10-CM Version

3. When a blood count is performed for an end-stage renal disease (ESRD) patient, and is billed outside the ESRD rate, documentation of the medical necessity for the blood count must be submitted with the claim.
4. In some patients presenting with certain signs, symptoms or diseases, a single CBC may be appropriate. Repeat testing may not be indicated unless abnormal results are found, or unless there is a change in clinical condition. If repeat testing is performed, a more descriptive diagnosis code (e.g., anemia) should be reported to support medical necessity. However, repeat testing may be indicated where results are normal in patients with conditions where there is a continued risk for the development of hematologic abnormality.

ICD-10-CM Codes That Do Not Support Medical Necessity

The ICD-10-CM codes in the table below can be viewed on CMS’ website as part of Downloads: Lab Code List, at
http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10.html

Code	Description
A18.59	Other tuberculosis of eye
A63.0	Anogenital (venereal) warts
B07.0	Plantar wart
B07.8	Other viral warts
B07.9	Viral wart, unspecified
D00.00	Carcinoma in situ of oral cavity, unspecified site
D00.01	Carcinoma in situ of labial mucosa and vermilion border

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 ASSESSSMENT OF ALL VENDORS, SYSTEMS, AND PAYERS

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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

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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**

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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)

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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

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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.

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GENTLE REMINDERS

- 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
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