ICD-10 Compliance Risk

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Speakers

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  • Immediate Past-President California Health Information Association
  • Current Position:
    – National Director Coding Quality, Education, Systems and Support: KP National Revenue Cycle
    – And ICD-10 Coding Education/Training Lead
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  The opinions and comments expressed during this presentation are those of the speaker and not of Kaiser Permanente.

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    – Associate Director, Navigant Consulting, Healthcare, Revenue Management Practice
    – Former positions: Revenue Cycle Director for Asante Health System (2002-2012) and previously with HCFA (now CMS)
Disclaimer

• This material is designed and provided to communicate information about clinical documentation, coding, and compliance in an educational format and manner. The author are 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.

• This is presentation is only a snapshot of some aspect of ICD-10 CM and should not be considered complete. All participants are encouraged to carefully review the full ICD-10 coding rules and guidelines, codes and content.

Goals/Objectives

• Understand Compliance Considerations with ICD-10
• Discuss Potential Risks surrounding ICD-10 Implementation
• Present Ideas to Decrease Revenue Cycle Compliance Risks and Others
• Review Next Steps
• Answer Questions
ICD-10 Delay

• “The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD-10 code sets as the standard for code sets under section 1173(c) of the Social Security Act (42 U.S.C. 1320d-2(c)) and section 162.1002 of title 45, Code of Federal Regulations.”

ICD-10 Code Set Partial Freeze

• The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.
• On October 1, 2012, October 1, 2013, and October 1, 2014 there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases as required under law.
• On October 1, 2015, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required under law. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.
• On October 1, 2016 (one year after implementation of ICD-10), regular updates to ICD-10 will begin.
• "The ICD-10 Coordination and Maintenance Committee will continue to meet twice a year during the partial freeze," states CMS. "At these meetings, the public will be asked to comment on whether or not requests for new diagnosis or procedure codes should be created based on the criteria of the need to capture a new technology or disease. Any code requests that do not meet the criteria will be evaluated for implementation within ICD-10 on and after October 1, 2016 once the partial freeze has ended."
ICD-10 Delay

• Remain focused
• Do not fall behind
• Keep stakeholders engaged
• Use this time to help line up compliance activities
• Reach out to your physicians and Medical Staff
  – Include and share education
  – Invite Office staff
  – Focus on documentation

Staying the Course
ICD-10 and Medicaid

ICD-10 Overview

The International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) is a coding of diseases, signs and symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO). The code set allows more than 14,400 different codes and permits the tracking of many new diagnoses.

ICD-10 is an updated version of the ICD-9 code sets. Several countries have taken the ICD-10 code set and modified it for use in their medical systems. The United States, through the National Center for Health Statistics, has developed the ICD-10-CM (or Clinical Modifications) version of the code set for use in the US. The Centers for Medicare & Medicaid Services (CMS) has created a new code set, ICD-10-PCS (or Procedure Coding System), for use. These code sets are considered classification code sets. They are at a higher level of information than some other medical code sets like the Systematized Nomenclature of Medicine (SNOMED), which is used by federal government systems for the electronic exchange of clinical health information. View additional information on ICD-10 Final Regulation and Training.

Current Use of ICD-9-CM Code Set and Other Code Sets

OIG Fraud Reporting

How to Contact the OIG Hotline

Consulting the OIG hotline is as easy as selecting from the following:

- OIG Hotline: 1-877-DETECT FRAUD
- OIG Hotline: 1-800-222-2252
- OIG Hotline: 1-800-487-2099

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# Healthcare Setting

<table>
<thead>
<tr>
<th>Setting</th>
<th>ICD-10-CM</th>
<th>ICD-10-PCS</th>
<th>CPT/HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Inpatient</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Hospital Outpatient Settings</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(OPS, ER, OP)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office &amp; Hospital</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settings (Prof Fee)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory (OP and Reference)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehab, SNF &amp; Long Term Care</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Others</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Compliance Risk

- Top areas for risk:
- Medical necessity,
- High-risk DRG coding,
- RACs, MACs, ZPICs, and MICs,
- Stark compliance,
- Physician documentation
- (source Report on Medicare Compliance)

Areas of Risk

1. Financial impacts and sustainability
2. Work force
3. Vendor readiness
4. Provider payments
5. Fraud, waste and abuse
6. Physician Practices
   - Documentation and coding
   - Claims and billing
   - Adjudication
Areas of Risk (con’t)

- Quality Reporting
- Core Measures
- Public Reporting
- Performance Improvement Initiatives
- Outcomes

- Clinicians
- ICD-9
- Bridge
- ICD-10

- HIM
- DNAF
- Inter-coder reliability
- Clinical Documentation improvement
- Mortality & morbidity adjustments
- CMIR reporting

- Revenue Processes
- Scheduling & Patient Access
- Orders & Prior Authorizations
- Coverage of Services
- Case Management
- Billing
- Payment

Importance of Compliance to Hospital Revenue

The Importance of Compliance

- Underpayments 41%
- Self Pay Bad Debt 12%
- Denials 47%

Denied claims account for nearly ½ of lost hospital revenue

Source: Health Care Advisory Board and HFMA
# ICD-10 Implications – Compliance Risks

- ICD codes are the currency of reputation capital
- ICD codes are cross-continuum data of the industry marketplace
  - Understanding patients & populations & utilization of services
  - Linking & comparing various providers involved in each episode
  - ACO bundled payment – HCC risk adjustments
  - Meaningful use requirements
  - Demonstrating value
    - How quality and outcomes measured
    - Identifying care processes for re-engineering/cost reduction
    - Developing and applying best practices and evidence-based medicine

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# LCDs and LCDs

- National Coverage Determination
  - Transmittals
  - Federal Register
  - Manuals

- Local Coverage Determination
  - MACs
LCDs and NCDs

- Lots of Rules that impact compliance:
  - Age Limits
  - Frequency limits
  - Non-covered diagnoses
  - Non-covered CPTs
  - Prior procedure requirement
  - Required modifiers
  - Required accompanying procedures
  - Required documentation
  - Secondary Dx requirements
  - Sex restrictions

Medical Necessity

- Difficult . . .
  - due to the pure complexity of the rules
  - due to incomplete or inaccurate documentation and code selection
  - integrating policies into existing software and workflows
  - Incorrect charge code capture/selection or CDM line item charge not agreeing with HIM code
  - staying current with changing policies
Coverage Issues

- ICD-10 Codes will be used to determine coverage:
  - X0801XA - Exposure to bed fire due to burning cigarette, initial encounter
  - 519 codes associated with types of falls
  - 1,397 codes associated with poisoning
  - 711 codes associated with self-harm
  - 898 codes associated with accident
  - 155 codes in the mental & behavioral disorders category including tobacco dependence codes

Quality Reporting

- Hospital-acquired conditions
- Medicare & Medicaid core measures
- Readmissions
- Risk of mortality/morbidity scores

- NQF is updating measures for ICD-10 codes

ICD-9 Baseline/Benchmarks → ??? → ICD-10 Codes

- Data availability to assess quality standards, patient safety goals, mandates and compliance
- Higher quality information for measuring healthcare service quality, safety, and efficiency
Specific tools are required to manage continuity of benchmarks, analytics, balanced scorecards & other key performance measures based on coded data.
### Hospital-Acquired Conditions (HACs)

<table>
<thead>
<tr>
<th>CMS Hospital-Acquired Conditions</th>
<th>No. of ICD-9 Codes</th>
<th>No. of ICD-10 Codes</th>
<th>Example ICD-10 Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreign Object Retained After Surgery</td>
<td>2</td>
<td>53</td>
<td>Type of procedure, type of complications such as adhesions, destruction, perforation</td>
</tr>
<tr>
<td>Air Embolism</td>
<td>1</td>
<td>1</td>
<td>Current CMS ICD-10 code specific to air embolism following transfusion, injection or infusion. Many other codes specific to procedures could be added.</td>
</tr>
<tr>
<td>Blood Incompatibility</td>
<td>5</td>
<td>5</td>
<td>No new concepts</td>
</tr>
<tr>
<td>Pressure ulcers, stage III &amp; IV</td>
<td>2</td>
<td>50</td>
<td>Specific site w/laterality</td>
</tr>
<tr>
<td>Falls &amp; certain trauma</td>
<td>1059</td>
<td>3664</td>
<td>Specific fractures, dislocations, burns, &amp; other injuries w/laterality</td>
</tr>
<tr>
<td>Catheter-associated UTI</td>
<td>1+10</td>
<td>1+14</td>
<td>Acute, chronic, w/wo hematuria</td>
</tr>
<tr>
<td>Vascular-catheter associated infection</td>
<td>1</td>
<td>2</td>
<td>NEC or NOS</td>
</tr>
<tr>
<td>Manifestations of Poor Glycemic Control</td>
<td>13</td>
<td>18</td>
<td>W/wo coma, type of manifestation, drug or chemical induced</td>
</tr>
<tr>
<td>Mediastinitis following CABG</td>
<td>1+9</td>
<td>1+231</td>
<td>Approach, site, laterality &amp; number of vessels</td>
</tr>
<tr>
<td>Surgical Site Infections following Ortho</td>
<td>1pdx+3=3+3</td>
<td>725+13</td>
<td>Approach, site, laterality &amp; type of device</td>
</tr>
<tr>
<td>DVT following Ortho</td>
<td>6+6</td>
<td>36+122</td>
<td>Approach, site, laterality &amp; type of device</td>
</tr>
<tr>
<td>Bariatric Surgery</td>
<td>1pdx+3=3</td>
<td>1pdx+2+49</td>
<td>Approach, site, &amp; method</td>
</tr>
</tbody>
</table>

More information will be able to be associated with HACs.

### Reputation Capital

- Reputation capital is the sum of the value of all enterprise intangible assets, including:
  - business processes
  - staff expertise
  - reputation for ethics and integrity
  - quality & safety,
  - sustainability, security & resilience

- Meeting expectations of the public while building a unique identity or brand creates trust and this trust builds the informal framework of a company. This framework provides “return in cooperation” and produces Reputation Capital. A positive reputation will secure a company’s or organization’s long-term competitive advantages.

- Reputation Capital is a corporate asset that can be managed, accumulated and traded in for trust, legitimization of a position within the industry, and a premium price for goods and services offered.

*Claims & ICD codes represent a significant portion of reputation capital.*
Utilization Tracking

• ICD-10 Codes will be used to explain utilization circumstances:
  – Z91.11 Patient’s noncompliance with dietary regimen
  – Z91.120 Patient’s intentional underdosing of medication regimen due to financial hardship
  – Z60.2 Problems related to living alone
  – Z74.2 Need for assistance at home and no other household member able to render care
  – R45.81 Low self-esteem
  – R46.1 Bizarre personal appearance

External Cause of Injury Codes

• External cause of injury coding allows for collection of population-based information needed to fully describe and document how and where an injury occurred (mechanism, activity and place of occurrence).
• External cause of injury codes are important for injury surveillance and for designing, implementing and monitoring injury prevention and control programs, i.e., domestic violence, workplace injury, motor vehicle crashes, etc. and public health research.
• External cause of injury codes can also be used by the health insurance for health care cost containment purposes.
• 837i provides for up to 12 external cause of injury codes
Strategies to Protect Outcomes Related to the Continuity of Your Data

• Review coding policies – for example, will coders add codes for mental and behavior disorders from documentation of any and all clinician specialties? Note: tobacco dependence codes are in this ICD-10 code category.

• Work with HIM to develop a plan to measure and accelerate inter-coder reliability for consistency of data. Until inter-coder reliability reaches a consistently high level, relying upon ICD-10 coded data for decision making may be suspect.

• Begin now to perform second level coding reviews of all adverse effect, hospital acquired and mortality cases and dual code in ICD-10 as well.

• Coding external causes can help patients to qualify for additional coverage or services and explain utilization – keys to population management so their capture is important

Strategies to Protect Outcomes Related to the Continuity of Your Data

• Model compliance reports on both ICD-10 codes and ICD-9 codes and compare trends and note areas for further analysis

• Discuss with CMO and Medical Executive Committee(s) the concept of a hold harmless period for ICD based reports used for re-credentialing/OPPE

• In turn, gain a renewed commitment from them to engage in documentation improvement initiatives while inter-coder reliability is being developed with ICD-10

• Discuss External Cause of Injury coding issues and patient portal issues with Board and Medical Executive Committee(s) and get their input
EMR & Patient Portals

• Learn how your EMR documentation and codes populate your patients’ personal health record and their data portals

• Will the portal be populated with actual codes, definitions of codes or more “patient-friendly” terminology?
  – Example: “Z60.2 Problems related to living alone” versus “living alone”

• Develop scripts and educate clinicians to empower them to inform their patients on why conditions are documented and coded and how they will be available in patient portals.

• Prevent adverse public press of by tracking codes and code combinations that can be used to challenge reputation assets

Operational Processes

• Identify current clinical use of ICD-9 (i.e., problem lists, EHR documentation)

• Engage leadership in impacted functional areas
  – Identify data users impacted (i.e., case management, marketing, decision support)
  – Document operational gaps, heat map, and identify linkages to technology and finance requirements
  – Determine ownership for readiness activities

• Evaluate current policies and procedures
• Identify relevant management reports
Clinical Documentation, Coding, and Training

- Determine workforce training required for ICD-10 preparation
  - Estimate capacity of current workforce to support transition
  - Review current clinical documentation and coding practices
  - Identify alternative training programs and internal/external training resources required
  - Review HR and training support infrastructure
  - Develop program timeline and budget
  - Determine who would need be trained based on assessment
  - Determine the method of training
  - Determine the training resources
  - Deliver

Documentation

- Focus on good documentation, which directly impacts accurate code assignment, billing and payment timing
- Be aware of new documentation guidelines in order to evaluate provider documentation for thoroughness and completeness
- Each provider’s documentation should paint a picture of the patient’s conditions and treatment
- Each provider’s documentation should tell the patient’s story
- Clinical documentation improvement (CDI) programs and/or activities
  - Physician query compliance
Coding

• More organizations are consolidating provider and professional coding
  – Same encounter, same Dx and same procedure
  – Matching
  – Efficiencies to be gained
• Consider whether coding policies differ by payer and result in an incomplete data warehouse

Do you Know Your Coded Data

**2013 Emergency Department Data**
**Top 10 Principal Diagnosis Codes**

<table>
<thead>
<tr>
<th>Principal Diagnosis Code</th>
<th>Principal Diagnosis Description</th>
<th># of Encounters</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>465.90</td>
<td>Acute upper respiratory infections of unspecified site</td>
<td>280,533</td>
<td>2.57%</td>
</tr>
<tr>
<td>789.00</td>
<td>Abdominal pain, unspecified site</td>
<td>231,508</td>
<td>2.12%</td>
</tr>
<tr>
<td>599.00</td>
<td>Urinary tract infection, site not specified</td>
<td>216,030</td>
<td>1.98%</td>
</tr>
<tr>
<td>785.50</td>
<td>Unspecified chest pain</td>
<td>199,779</td>
<td>1.83%</td>
</tr>
<tr>
<td>784.00</td>
<td>Headache</td>
<td>197,905</td>
<td>1.82%</td>
</tr>
<tr>
<td>780.60</td>
<td>Fever</td>
<td>164,990</td>
<td>1.51%</td>
</tr>
<tr>
<td>786.59</td>
<td>Other chest pain</td>
<td>157,890</td>
<td>1.45%</td>
</tr>
<tr>
<td>382.90</td>
<td>Unspecified otitis media</td>
<td>150,199</td>
<td>1.38%</td>
</tr>
<tr>
<td>959.01</td>
<td>Head Injury, Unspecified</td>
<td>130,009</td>
<td>1.29%</td>
</tr>
<tr>
<td>462.00</td>
<td>Acute pharyngitis</td>
<td>127,526</td>
<td>1.17%</td>
</tr>
</tbody>
</table>

**Percentage of total ED Encounters (not resulting in an admission)** 17.76%
### ICD-9-CM/ICD-10-CM DX: Acute Respiratory Infection

- **ICD-9-CM**
  - respiratory 519.8
  - chronic 519.8
  - influenzal (acute) (upper) (see also Influenza) 487.1
  - lung 518.89
  - rhinovirus 460
  - syncytial virus 079.6
  - upper (acute) (infectious) NEC 465.9
  - with flu, grippe, or influenza (see also Influenza) 487.1
  - influenzal (see also Influenza) 487.1
  - multiple sites NEC 465.8
  - streptococcal 034.0
  - viral NEC 465.9

- **ICD-10-CM**
  - respiratory NEC(tract) J98.8
  - acute J22
  - chronic J98.8
  - influenzal(upper) (acute) - see Influenza, with, respiratory manifestations NEC
  - lower(acute) J22
  - chronic- see Bronchitis, chronic
  - rhinovirus J00
  - syncytial virus, as cause of disease classified elsewhere B97.4
  - upper NOS(acute) J06.9
  - chronic J39.8
  - streptococcal J06.9
  - viral NOS J06.9

### ICD-9-CM/ICD-10-CM DX: Abdominal Pain

- **ICD-9-CM**
  - 789.0 Abdominal pain
    - Cramps, abdominal
    - The following fifth-digit subclassification is to be used for codes 789.0, 789.3, 789.4, 789.6
      - 0 unspecified site
      - 1 right upper quadrant
      - 2 left upper quadrant
      - 3 right lower quadrant
      - 4 left lower quadrant
      - 5 periumbilic
      - 6 epigastric
      - 7 generalized
      - 9 other specified site
      - multiple sites

- **ICD-10-CM**
  - R10.0 Acute abdomen
  - R10.1 Pain localized to upper abdomen
  - R10.2 Pelvic and perineal pain
  - R10.3 Pain localized to other parts of lower abdomen
  - R10.8 Other abdominal pain
    - R10.81 Abdominal tenderness
    - R10.82 Rebound abdominal tenderness
    - R10.83 Colic
    - R10.84 Generalized abdominal pain
  - R10.9 Unspecified abdominal pain
Physician Office Statistics

- Physician office visits
- Number of visits: 1.0 billion
- Number of visits per 100 persons: 332.2
- Percent of visits made to primary care physicians: 55.5%
- Most frequent principal illness-related reason for visit: cough
- Most commonly diagnosed condition: essential hypertension

Source: CDC

ICD-9-CM/ICD-10-CM DX: Cough

- ALPHABETIC LIST
- ICD-9-CM
- Cough 786.2
- with hemorrhage (see also Hemoptysis) 786.39
- affected 786.2
- bronchial 786.2
- with grippe or influenza (see also Influenza) 487.1
- chronic 786.2
- epidemic 786.2
- functional 306.1
- hemorrhagic 786.39
- hysterical 300.11
- laryngeal, spasmodic 786.2
- nervous 786.2
- psychogenic 306.1
- smokers' 491.0
- tea tasters' 112.89

- ICD-10-CM
- Cough(affected) (chronic) (epidemic) (nervous) R05
- with hemorrhage- see Hemoptysis
- bronchial R05
- with grippe or influenza- see Influenza, with respiratory manifestations NEC
- functional F45.8
- hysterical F45.8
- laryngeal, spasmodic R05
- psychogenic F45.8
- smokers' J41.0
- tea taster's B49
ICD-9-CM/ICD-10-CM DX: Essential Hypertension

- ICD-9-CM
- I10
  - Essential (primary) hypertension
  - high blood pressure
  - hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)

Coded Data is Valuable

- Public Health Epidemiology & Surveillance
- Healthcare Policy
- Benchmarking Quality of Care
- Patient Safety
- Research
- Reimbursement
Standards of Ethical Coding: AHIMA

- Coding professionals should: Apply accurate, complete, and consistent coding practices for the production of high-quality healthcare data.
- Report all healthcare data elements (e.g. diagnosis and procedure codes, present on admission indicator, discharge status) required for external reporting purposes (e.g. reimbursement and other administrative uses, population health, quality and patient safety measurement, and research) completely and accurately, in accordance with regulatory and documentation standards and requirements and applicable official coding conventions, rules, and guidelines.
- Assign and report only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, rules, and guidelines.
- Query provider (physician or other qualified healthcare practitioner) for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation (e.g. present on admission indicator).
- Refuse to change reported codes or the narratives of codes so that meanings are misrepresented.
- Refuse to participate in or support coding or documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or skew data by means that do not comply with federal and state statutes, regulations and official rules and guidelines.
- Facilitate interdisciplinary collaboration in situations supporting proper coding practices.
- Advance coding knowledge and practice through continuing education.
- Refuse to participate in or conceal unethical coding or abstraction practices or procedures.
- Protect the confidentiality of the health record at all times and refuse to access protected health information not required for coding-related activities (examples of coding-related activities include completion of code assignment, other health record data abstraction, coding audits, and educational purposes).
- Demonstrate behavior that reflects integrity, shows a commitment to ethical and legal coding practices, and fosters trust in professional activities.

Source: AHIMA 09/08

Revenue Cycle: Pre-Service

- Referrals & Orders
- Authorizations
- ABNs/Waivers
- Certifications

- Identify key revenue cycle functions that are currently using ICD-9 (i.e., scheduling, financial clearance, claims processing, denials management)
  - Outline ICD-10 action steps and implementation approach, including:
    - Staffing/Training
    - Process/Policy and procedure redesign
    - Communications
    - Compliance concerns
Revenue Cycle: Middle

- Inter-coder reliability
- Coding
  - HIM Credentialed Coders
  - Data entry
  - CAC

Revenue Cycle: Pre-Billing

- Data governance and data integrity
- Billing edits – host AR system
- Billing edits - Clearinghouse
Revenue Cycle: A/R Management

• Advise on potential impact to coding productivity and DNFB/billing/payment changes
• Estimate potential impact to cash flow during transition and long term
• Identify dual processes and related reporting
  – Receiving payable claims during the transition period from ICD-9 and ICD-10 codes
  – Matching referrals that contain ICD-9 and ICD-10 codes

It is predicted that denial rates will increase by 100 percent to 200 percent post-implementation, with a corresponding increase in accounts receivable days by 20 percent to 40 percent.

Revenue Cycle: Back End

• Payer edits – 277 codes
• CAS codes
• Denials
Claims/Denials

- Testing with external payers
- Slow down of claim processing
  - Turn around time
  - Adjudication
- Increase in denials
- Linkage to PreCertification and Approvals
  - Coding
  - Diagnosis codes – edits
  - Procedure codes – not accepted
  - Lower payment
- Process flow and staffing needs
- Proactive
  - Ensure your physician order, scheduling, and registration processes and systems store chief complaints in code format today, consistently, with no free text.
  - Have a denial management team/committee

Payer Contracting

- Understand payer approach to code mapping, APR DRGs and impact to reimbursement
  - Evaluate potential changes to reimbursement formulas, contracts, etc.
  - Understand change in net reimbursement based on changes in acuity and new codes
  - Identify tools to enable payment modeling with new codes
  - Understand current payment monitoring and compliance tools and practices
  - Define future state under payment monitoring approaches and tools
  - Draft contracting/negotiation plan
  - Draft and prioritize list of payers (contracted and non-contracted)
  - Confirm payers ability for reimbursement under ICD-9 and ICD-10
  - Confirm payer assumptions regarding cash flow during transition and long term
Physician

• Identify necessary updates to clinical documentation practices such as templates for EHRs to support data needs
• Consider use of computer assisted coding solutions for professional fee ICD-10 code assignment
• Physician training for clinical documentation requirements should be phased over next 3 years
• Link clinical outcomes data and quality reporting

Physician (con’t)

• Find out how to get your EM services documented to support the given level based on concerns from the Federal Government
• Diagnostic testing is a part of many offices/facility and you need to be able to support the reason why you are ordering them (along with examples)
• With all the new issues of physical therapy you will need to know the areas that the OIG has identified as not being in compliance
• Cloning of medical records continues to cause compliance issues – see what the OIG states
• The actual provider of services being billed must be clearly documented and supported as well as licensed and credentialed to perform those services, do you have this information in your compliance manuals?
• Review of Medicare Part B payments for suppliers of power mobility devices (PMD) to determine whether such payments were in accordance with Medicare requirements
### Physician (con’t)

- Insights on whether Medicare payments for PMD claims submitted by medical equipment suppliers are medically necessary and are supported in accordance with requirements at 42 CFR § 410.38
- Discussion on chiropractic services paid by Medicare to identify trends in payment, compliance, and fraud vulnerabilities and offer recommendations to improve detected vulnerabilities
- Review the extent to which physicians and suppliers participated in Medicare and accepted claim assignment during 2013
- Review of Medicare payments for high-cost diagnostic radiology tests to determine whether they were medically necessary and the extent to which utilization has increased for these tests
- Overview of physicians’ coding on Medicare Part B claims for services performed in ambulatory surgical centers and hospital outpatient departments to determine whether they properly coded the places of service

### Risk Mitigation Strategies for Vendor Relationships

- Require dates for deliverables and track to those dates
- Ensure frequent/regular communication updates from each vendor partner
- Prepare for remediation plan with commitment from vendor partner
- Demand a detailed explanation, if the vendor misses or adjusts timelines
- Support an interdependency relationship (“Your success is my success”) with vendor partners, which must be guided by enterprise high level executives to ensure prompt remediation and resources are made available as needed
Next Steps

– Situational compliance analysis
– Inclusion of key stakeholders
– Assess impact with additional year
– Formulate strategies and identify your risk and your goals
– Continue to Develop and Deliver education/training plans for employees at all levels
– Develop information systems/technology systems change implementation plan that includes testing and "go live" dates
– Work on physician engagement
– Plan for documentation changes

Watch CMS Communications
Summary

• Avoid Complacency
• Be apart of the ICD-10 implementation and readiness planning
• Have checks and balances in place
• Reach out to all areas of healthcare workflow and Revenue Cycle

Questions/Answers
Thank you

References/Resources

- CMS/gov/ICD10
- AHIMA.org