HCCA Regional Conference
Dallas, Texas
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ICD-10 COMPLIANCE

SPEAKER

Gloryanne Bryant, RHIA, CDIP, CCS, CCDS
+ AHIMA Approved ICD-10-CM/PCS Trainer
+ 30+ year HIM Professional and Leader
+ Past-President CHIA
+ CHIA ICD-10 Advocacy Task Force Chair

+ National Director Coding Quality, Education, Systems and Support, Kaiser Permanente Revenue Cycle
DISCLAIMER

- This material is designed and provided to communicate information about ICD-10 Compliance in an educational format and manner.
- The presenter is not providing or offering legal advice, but rather practical and useful information and tools to achieve results in the area of ICD-10 readiness, implementation and adoption.

GOALS/OBJECTIVES

- Review and learn about key ICD-10 compliance risk areas
- Understand the documentation changes in key areas and physician query preparations
- Identify MS-DRG shifts that could be improved upon
- Obtain details on your compliance check list for ICD-10 implementation planning
- Q&A
ICD-10 COMPLIANCE

- **It's crunch time for ICD-10 compliance**

  Health Data Management

  For providers working on the move from ICD-9 to ICD-10, the government's October 2015 compliance deadline may still seem far off. But it's not. "Many of you may think, 'Well, I have another year to go,'" said Denesecia Green of CMS' Administrative Simplification Group during a Medicare Learning Network webinar. But time is of the essence, Green said. Granted, in December 2014 there were some indications that another attempt would be made to legislatively extend the deadline.

- **January 2015**

HOUSE ENERGY AND COMMERCE COMMITTEE

- **2/2015**

  - House Energy and Commerce Committee held testimony on ICD-10 2/11/2015

  - Chairman Fred Upton (R-MI) and House Rules Committee Chairman Pete Sessions (R-TX) issued a statement saying that they would hold hearings on ICD-10 and stay in communication with the Centers for Medicare and Medicaid Services (CMS) “to ensure that the [ICD-10-CM/PCS] deadline can successfully be met by stakeholders.”

- Those who testified: AHIMA
ICD-10 COMPLIANCE

CHECKS AND BALANCES

Avoiding the Top 5 Risks of the ICD-10 Conversion

The changeover to ICD-10 will be costly for many practices. This white paper includes the 5 major risks of the ICD-10 transition that your practice should expect:

- Lack of preparation by your billing, practice management, and EHR vendor
- Lack of preparation by your payers
- Insufficient training for your staff
- Reduced physician and staff productivity
- Financial risk associated with higher transition costs

January 2015

ICD-10 FACTS TO KNOW

- **Q:** What is ICD-10-CM/PCS?
  - **A:** ICD-10-CM (International Classification of Diseases, 10th Version-Clinical Modification) is designed for classifying and reporting diseases. ICD-10-PCS (Procedure Classification System) replaces the ICD-9-CM procedure coding system, and will only be required for facilities reporting on hospital inpatient services. When speaking of both these new classifications, the term “ICD-10” is often used.

- **Q:** Who has to comply with ICD-10?
  - **A:** All HIPAA-covered entities must convert to ICD-10-CM for reporting diagnoses and ICD-10-PCS for facility reporting of inpatient services, from the 35 year old ICD-9-CM version.

- **Q:** Why does the U.S. need to replace ICD-9-CM?
  - **A:** Developed in the 1970s, the ICD-9-CM code set no longer fits with the needs of the 21st century healthcare system. ICD-9-CM is used for many more purposes today than when it was originally developed and is no longer able to support current health information needs.

- **Q:** Has the pace of the ICD-10 transition been too rapid?
  - **A:** For the past 14 years, healthcare organizations have known that ICD-10 implementation would occur. This provided plenty of time to prepare for the transition. The longer implementation takes, the more it will cost and the more the quality of healthcare data will suffer.

- **Q:** Why is it important not to delay the implementation of ICD-10?
  - **A:** ICD-10-CM and ICD-10-PCS must be adopted as soon as possible to reverse the trend of deteriorating health data. Never in U.S. history have we used the same version of ICD for 35 years.

- **Q:** Will ICD-10 procedure codes be used for both inpatient and outpatient hospital services?
  - **A:** No. ICD-10 procedure codes are designed only for hospital reporting of inpatient services. Current Procedural Terminology (CPT) codes will continue to be used for physician and outpatient services.

- **Q:** Do physicians need to use all the codes in ICD-10?
  - **A:** Healthcare providers will not use all the codes in the classification system; rather they will use a subset of codes based on their practice. The ICD-10-CM code set is like a dictionary that has thousands of words, but individuals use some words very commonly while other words are never used.
ICD-10 FACTS TO KNOW (CON’T)

Q: Does ICD-10 compete with other healthcare initiatives that require time and resources to implement?
A: No. The industry has had 14 years to prepare for the implementation. The benefits of ICD-10 will improve national healthcare initiatives such as Meaningful Use, value-based purchasing, payment reform and quality reporting. Without ICD-10 data, there will be serious gaps in the ability to extract important patient health information needed to support modern-day research, and move to a payment system based on quality and outcomes.

Q: What is the value of ICD-10?
A: The improved clinical detail, better capture of medical technology, up-to-date terminology, and more flexible structure will result in:
- Higher quality information for measuring healthcare service quality, safety, and efficiency
- Improved efficiencies and lower costs
- Greater coding accuracy and specificity
- Greater achievement of the benefits of electronic health records
- Recognition of advances in medicine and technology
- Improved ability to measure outcomes, efficacy, and costs of new medical technology
- Better support of medical necessity of services provided
- Fewer claims denials
- Improved ability to determine disease severity for risk and severity adjustment
- Global healthcare data comparability
- Improved ability to track and respond to public health threats
- Reduced need for manual review of health records to perform research and data mining and adjudicate reimbursement claims
- Reduced need for supporting documentations to support information reported on claims
- Reduced opportunities for fraud and improved fraud detection capabilities
- Development of expanded computer-assisted coding technologies that will facilitate more accurate and efficient coding and alleviate the coder shortage
- Space to accommodate future expansion

WHAT DOES ICD-10 COMPLIANCE MEAN?

ICD-10 compliance means that HIPAA-covered entities must utilize ICD-10 codes for healthcare services rendered on or after the compliance date.

<table>
<thead>
<tr>
<th>Pre-Compliance</th>
<th>Compliance Date</th>
<th>Post-Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS and other payers will only accept, recognize, and process ICD-9 codes. Claims billed with ICD-10 codes will be rejected.</td>
<td>CMS and other payers will only accept, recognize, and process ICD-10 codes. Claims billed with ICD-9 codes will be rejected.</td>
<td></td>
</tr>
</tbody>
</table>
ICD-10 COMPLIANCE

- ICD-10 Compliance is mandatory for all HIPAA-covered entities, including those who do not handle Medicare claims. There are no exceptions to any HIPAA-covered entities.
- Organizations that are not governed by HIPAA who use ICD-9 codes should be aware that their coding may become obsolete in the transition to ICD-10.
- For guidelines on what qualifies as a HIPAA-covered entity, visit http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/index.html.

KEY STEPS . . .

- Ensure top leadership understands the breadth and significance of the ICD-10 change.
- Assign overall responsibility and decision-making authority for managing the transition.
- Plan a comprehensive and realistic budget.
- Ensure involvement and commitment of all internal and external stakeholders.
- Adhere to a well-defined timeline
RISK AREAS

- 1. Financial impacts and sustainability
- 3. Payer & Vendor Readiness: end to end
- 4. Systems – internal and external
- 5. Physician & Provider payments
- 6. Documentation and Coding
- 7. AR or Discharge Not Final Coded; productivity and denials

REALIZE SUCCESS

- Remediation
- Testing,
- Financial impact analysis
- Education, e-learning and training
- Verification and validation
- Operational readiness
- Operational stabilization
- Optimization
- Change Management
FINANCIAL IMPACTS AND SUSTAINABILITY

Not a free ride to implementation

<table>
<thead>
<tr>
<th></th>
<th>Typical Small Practice</th>
<th>Typical Medium Practice</th>
<th>Typical Large Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>$2,700-$5,000</td>
<td>$4,800-$7,100</td>
<td>$75,100</td>
</tr>
<tr>
<td>Assessment</td>
<td>$4,300-$5,000</td>
<td>$6,525-$9,600</td>
<td>$19,320</td>
</tr>
<tr>
<td>Vendor/Software Upgrades</td>
<td>$0-$560,000</td>
<td>$0-$200,000</td>
<td>$0-$52,000,000</td>
</tr>
<tr>
<td>Process Remediation</td>
<td>$3,312-$5,701</td>
<td>$6,211-$12,350</td>
<td>$14,874-$31,431</td>
</tr>
<tr>
<td>Testing</td>
<td>$15,248-$28,805</td>
<td>$47,956-$93,398</td>
<td>$428,740-$880,660</td>
</tr>
<tr>
<td>Productivity Loss</td>
<td>$8,500-$18,250</td>
<td>$72,649-$166,649</td>
<td>$726,487-$1,666,487</td>
</tr>
<tr>
<td>Payment Disruption</td>
<td>$22,579-$51,000</td>
<td>$75,263-$534,498</td>
<td>$752,630-$5,344,976</td>
</tr>
<tr>
<td>Total Costs</td>
<td>$56,639-$526,105</td>
<td>$213,364-$582,735</td>
<td>$2,017,151-$5,018,364</td>
</tr>
</tbody>
</table>

The 2014 estimates include much higher figures due in part to significant post-implementation costs, including the need for testing and the potential risk of payment disruption. Source: AMA website

CMS PLANNING FOR SMALL & MEDIUM PHYSICIAN PRACTICES

This recent study indicated much lower costs for physicians.
WORK FORCE READINESS & CHANGE MGMT.

- Awareness
- Assessment
- Educate
- Train
- Reinforce
- Continue and communicate often
- When it comes to change, communication is critical. It touches every part of the ICD-10 implementation.
- Change communications are the planned and targeted messages designed for specific audiences to fill specific objectives or goals
- To be effective, we want follow the 3 C’s of communication:
  + Comprehensive
  + Clear
  + Consistent

PAYER & VENDOR READINESS

- Assessment all payers and vendors: list
- Update/upgrade, revise
- Testing
  + Internal and external
- Changes and Retest
- Final check

Evaluate your existing reimbursement patterns to gauge your volumes.
In this Special Edition article, the Centers for Medicare & Medicaid Services (CMS) clarifies the policy for processing split claims for certain institutional encounters that span the ICD-10 implementation date (that is, when ICD-9 codes are effective for that portion of the services rendered on September 30, 2015, and earlier, and when ICD-10 codes are effective for that portion of the services rendered on October 1, 2015, and later).
**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
NCD AND LCD

- National Coverage Determination
  - Transmittals
  - Federal Register
  - Manuals

- Local Coverage Determination
  - MACs

- 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
Coding changes associated with ICD-10: GEMs (General Equivalence Mapping)

- Validate with your clearinghouse they are ready
- Validate with your payers – have a list
- Validate with internal quality software is updated and ready
- End to end testing: internal and external – validate this is planned or has occured
PHYSICIAN & PROVIDER PAYMENTS

- Medical necessity: specific ICD-10-CM codes (diagnosis)
- New updated superbills: Physician practices
  + Will not use ALL 71,000 codes; only those specific to practice like today
- Delays in adjudication: slower payment cycle
- Denials will slow down payments: same as today – contingency plans
- Accuracy of coded data: claims data
- System issues?
- Overall implementation planning and related expenses

OVERVIEW OF CONVERTING A PHYSICIAN PRACTICE TO ICD-10: STEP-BY-STEP

- Get a plan
  + Identify which ICD-9 codes you use heavily
  + Identify the staff that needs to be trained in coding and/or documentation
  + Contact vendors to learn their plans, ICD-10 related costs to the practice, and resources available to the practice
  + Contact the specialty society for any resources available to the practice
  + Visit the CMS website for useful tools and materials
- Get trained
  + Buy or download an ICD-10 diagnosis codebook
  + Arrange and implement ICD-10 coding training for staff
  + Arrange and obtain documentation training for physicians and other clinicians
  + Crosswalk common diagnosis codes to ICD-10 and identify new requirements or differences in essential documentation
  + Sign up for key CMS webinars to increase understanding of the ICD-10 environment
OVERVIEW OF CONVERTING A PHYSICIAN PRACTICE TO ICD-10: STEP-BY-STEP

- Update internal practice tools
  - Convert superbills to ICD-10
  - Convert other materials to ICD-10, such as authorizations, orders and referrals
  - Identify common code-related causes for current claim denials and identify areas where ICD-10’s specificity in documentation and code assignment can address this
  - Obtain payer medical policies with ICD-10 codes for comparison

- Work with vendors and payers
  - Arrange and implement ICD-10 software upgrades
  - Train staff on use of new software, either directly or via the vendor
  - Identify EHR documentation templates and assess how they support ICD-10 specificity for claims submission and medical necessity
  - Engage payers on any discrepancies and omissions in ICD-10 coding for medical policies
  - Identify if payers anticipate any changes in processing and payment due to ICD-10
  - Identify availability of testing with major payers

- Test the process
  - Perform testing on systems within the practice
  - Perform end-to-end testing with vendors and/or payers
  - Identify and correct issues raised during testing
  - Educate staff on the impact of ICD-10 to payer edits, adjudication, and other claims elements to processes within the practice

- Repeat!

CMS SMALL PRACTICE PROJECT

http://www.roadto10.org/
CMS SMALL PRACTICE PROJECT

- CMS partnership with AHIMA
- Training and technical assistance in 18 targeted states and 5 designated specialties
- AHIMA Component State Associations (CSA) asked to identify a point of contact within each state to work with CMS
- AHIMA has updated information and provided links to several AHIMA coding resources for posting on the CMS site
  - In CSAs where there has been training, the CSA contacts have reached out to their members to support the CMS training programs by attendance and also identifying physician practice facilities to target.

http://www.roadto10.org

DOCUMENTATION

- Specificity: needed in order to advance healthcare
- Some increased time: providers need to learn new terminology requirements
- Conduct a documentation assessment
- Paper vs electronic (EHR)
- Templates and smart phrases may help
- Work closely with HIM/Coding and CDI leadership
CLINICAL DOCUMENTATION IMPROVEMENT (CDI)

- Having a CDI program may prove to be beneficial to your ICD-10 readiness
- Participate in your documentation assessment
- Develop documentation tips
- Provide physician awareness and work with Physician Champion on inservicing Medical Staff (small groups or one-on-one)

CLINICAL DOCUMENTATION IMPROVEMENT (CON’T)

- Readiness
- A good CDI program includes the following:
  + Assessment – Internal or a trusted third-party vendor can evaluate current documentation practices to identify inefficiencies and offer strategies for improvement.
    - This can identify and decrease risk
    - Compliance oversight?
  + Getting physician/clinician buy-in – To obtain physician/clinician engagement, determine what their educational preferences are; explain the benefits of education to them; and provide training and programs with minimal impact on their daily routine.
CLINICAL DOCUMENTATION IMPROVEMENT (CON’T)

- Education – A CDI program with an ongoing education component will ensure new levels of documentation specificity.
  - CDI staff to be educated
  - Assist with Physician educational efforts
- Follow-up and monitoring – This will provide ongoing quality improvement and validate return on investment.
- Policies and Procedures - review and update
  - Provide validation of this
- Query language – review and update
  - Provide validation of this

DOCUMENTATION TIPS

- AHIMA has developed and made available to the healthcare community free tips
- Developed to focus on key terminology, wording to assist with specificity in capturing ICD-10 codes
- Utilization in all settings

- EXAMPLE:
  - MRSA/MSSA
  - Methicillin-resistant Staphylococcus aureus
    - Include documentation of “MRSA infection” when the patient has that condition.
    - Document if sepsis and/or septic shock is present.
    - Document any associated diagnoses/conditions.
  - Methicillin susceptible Staphylococcus aureus
    - Include documentation of “MSSA infection” when the patient has that condition.
    - Document if sepsis, and/or septic shock is present.
    - Document any associated diagnoses/conditions.
AHIMA ICD-10 DOCUMENTATION TIPS NOW AVAILABLE:
HTTP://BOK.AHIMA.ORG/PDFVIEW?OID=300621

These are FREE and available for EVERYONE, including Physician Practices!

CODING READINESS

- Assessment of Quality
- Education and Training plan
  + Detailed and multi-phased
- Policies and Procedures - review and update
  + Provide validation of this
- Query language – review and update
  + Provide validation of this
- Vendor contracts to be updated
  + Pricing model
  + Ensure their staff are appropriately educated, etc.
  + Provide validation of this
CODING AUDITS/REVIEWS

- Part of the Compliance Process: pre and post go live
- **Frequent reviews** – To promote consistency in complete and accurate reporting of a facility’s patient population
- **A variety of chart selection methodologies** – Results in the most complete, well-rounded compliance program and yields additional benefits, including accurate reimbursement in a more timely fashion and valuable education to coders
- **Ongoing monitoring and evaluation** – To encourage continuous performance improvement
  - + Data mining
- **Strong coder feedback** – To provide timely learning re-enforcement
- **Coder education** – To offer continuous and timely support and feedback to the coding staff
- **A trusted vendor partner** – To assist in developing the best documentation and coding audit compliance plans based on an organization’s specific needs

PHYSICIAN QUERIES

- Review and update all physician query forms; both paper and electronic
- Ensure they contain Nonleading language/wording
- Being now
- Use before go live to begin obtaining specific documentation
**MS-DRGs**

- Medicare-Severity Diagnostic Related Groups
  - Medicare FFS
- MS-DRGs come in threes, differing only in severity. For example:
  - 163 Major chest procedures w MCC
    - Highest severity
  - 164 Major chest procedures w CC
    - Medium severity
  - 165 Major chest procedures w/o CC/MCC

**MS-DRG SHIFT**

- Various assessments found that the DRG assigned to an ICD-10 claim did not always match the DRG assigned to an ICD-9 source claim.
  - Percentage of change
    - 1%
- The change in DRGs for the ICD-10 claim related to an ICD-9 claim is referred to as “DRG Shift”.
- Identify target MS-DRGs for comparison from ICD-9 to ICD-10 Evaluate volume comparison
- Determine causes of changes in volume
- There will be “some” changes in MS-DRGs due to coding guideline changes.
  - Anemia vs malignancy
- Some changes in MS-DRG assignment will occurred due to code specificity
- Some changes due to MCC/CC movement
MS-DRG SHIFT (CONT’D)

- Sequencing Anemia as the principal diagnosis under ICD-9 groups these cases to MS-DRG 812.
- However, the ICD-10-CM guideline states to sequence the appropriate code for the malignancy as the principal or first-listed diagnosis followed by code D63.0, Anemia in Neoplastic Disease.
- Sequencing the malignancy first under ICD-10 usually will group these cases to a slightly higher-weighted MS-DRG related to cancer.
In ICD-9, there are three codes for hypertension:

- **401.0** Malignant essential hypertension. (CC)
- **401.1** Benign essential hypertension. (Not CC or MCC)
- **401.9** Unspecified essential hypertension. (Not CC or MCC)

Need a report

- ICD-10-CM code I10, is Essential (primary) hypertension, because the concepts of malignant and benign as a way of specifying a type of hypertension have been dropped from the ICD classification.
- Hypertensive crisis and coded in the ICD-9 system as malignant hypertension) could be accompanied by a whole host of CC/MCC qualified conditions, including N17.9, Acute kidney failure, unspecified, which is a CC.

Under ICD-9, Esophageal Hemorrhage has its own unique code, 530.82 and groups to MS-DRG 368 (with the addition of an MCC).

Also, ICD-9 code 530.89, Other Disorders of Esophagus, groups to MS-DRG 391 (with the addition of an MCC). Code 530.89, which is not an MCC, is the closest match to the ICD-10 code, K22.8, Other Diseases of Esophagus which includes esophageal hemorrhage in its definition and is the cause of about 90% of the weight change. A record without an MCC will shift to a lower-weighted MS-DRG.
MS-DRG 191, CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH CC

- Under ICD-9, code 491.21, Acute Exacerbation of COPD can be further specified to:
  - COPD with Acute Bronchitis, 491.22
  - COPD with Acute Exacerbation of Asthma, 493.22

Under ICD-9, all of these codes are listed as CCs. Cases will group to MS-DRG 191, Chronic Obstructive Pulmonary Disease with CC when either condition above is sequenced as the principal diagnosis followed by one of the other conditions listed above as a secondary diagnosis.

CONTINUED: MS-DRG 191, CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH CC

- Under ICD-10, one code, J44.1, COPD with Acute Exacerbation includes chronic obstructive bronchitis, chronic obstructive asthma, and chronic obstructive pulmonary disease in its description.

- Will group to a lower-weighted MS-DRG 192, Chronic Obstructive Pulmonary Disease without CC/MCC in ICD-10 because these additional conditions will not be coded separately.
QUALIFIED STAFF?

- ▶ CODING CERTIFICATION: Will coders need to gain additional certification for ICD-10?
- AAPC does require a recertification (proficiency assessment).
  - + Confirm your employee’s are recertified
  - × Although AAPC does allow time to complete
- AHIMA requires self-study and hours of training on ICD-10.
  - + Confirm your employee’s have received hours
- Best Practice is to: Contact the association through which you acquired your certification.

AAPC PROFICIENCY ASSESSMENT

- Successful completion of this assessment by December 31, 2015 satisfies AAPC’s ICD-10 certification maintenance requirement and demonstrates proficiency of ICD-10-CM format and structure, groupings and categories of codes, ICD-10-CM official guidelines, and coding concepts.
- 3.5 hour time limit
- Two (2) attempts at passing
- 80% score required
- 75 multiple choice questions
- Open-book, online, unproctored
- ICD-10-CM only (ICD-10-PCS will not be covered in the assessment)
- No CEUs given
- $60 administration fee (for each two attempts)
AR OR DISCHARGE NOT FINAL CODED

- It is expected that there will be a slow down in processing coded encounters and will billing.
- Coding will need to get as caught up as they can before go live.
- Backup staffing; OT and contract coding from external vendors will be needed.
- Claim/billing will also need to prepare for the slow down and then once they receive claims to process to quickly perform.

Monitoring and tracking is important!

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, obstruction, 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</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. Education and awareness!

## KEY

- Coding accuracy
- Clinical documentation improvement
- Medical necessity compliance
- Revenue integrity
- Denial management
- Operational efficiencies
**HR & STAFFING TIPS**

- HR & Staffing Risks
- Manage employee burnout: lots of change needs support
  - Change Management
- Creative Staffing solutions
  - Pool work and staffing
  - Hire differently
  - Remote workforce
  - Grow your own experts; build the workforce

**CMS: ICD-10**

- The Centers for Medicare and Medicaid Services (CMS) has an extensive list of resources that explain how to prepare for ICD-10 implementation. You can download:
  - Checklists
  - Timelines
  - Fact sheets
  - Tutorials
- The World Health Organization (WHO) has a free ICD-10 Training Tool. (But it's not the ICD-10-CM/PCS versions that U.S. healthcare organizations will be using)
INFORMATION AVAILABLE

- The Healthcare Information and Management Systems Society (HIMSS) ICD-10 Playbook has a great deal of content to help plan the ICD-10 transition.
- The American Health Information Management Association (AHIMA) has toolkits, tips, articles, seminars, webinars and workshops.
- Reach out to your local professional societies. They should be planning educational and training programs.

DISEASES WE ALL CARE ABOUT . . . ICD-10 CAN HELP!

- Alzheimer's Disease: every 67 seconds someone in the United States develops this disease! Today, more than 5 million Americans are living with the disease. Almost two-thirds of Americans with Alzheimer's are women.

- Parkinson's: Despite decades of intensive study, the causes of Parkinson's remain unknown. Many experts think that the disease is caused by a combination of genetic and environmental factors, which may vary from person to person. As many as one million Americans live with Parkinson's disease and every year 60,000 Americans are diagnosed with this disease.

ICD-10 offers greater specificity and details with the code and descriptions than ICD-9. Disease Research and Mgmt. can be improved.
DISEASES WE ALL CARE ABOUT . . . ICD-10 CAN HELP!

- Neoplasms: In 2014, there will be an estimated 1,665,540 new cancer cases diagnosed and 585,720 cancer deaths in the US.
- Cancer remains the second most common cause of death in the US, accounting for nearly 1 of every 4 deaths.
  + Visit: http://www.cancer.org/research/cancerfactsstatistics/

- “Chasing the Cure”...... Better coded data will help . . . So let’s get ICD-10 implemented!

ICD-10 COMPLIANCE CHECK LIST

- Review your ICD-10 Implementation Plan
- Obtain an update from key operational areas of your organization or practice
  + Systems
  + Payers
  + Documentation and Coding
- Make adjustments
- Continue with education and re-enforcement
  + Repetition is good
- System testing: join the CMS testing?
- Require “status reports” monthly
- Plan for impact to AR, denials, etc.
- Include Go-Live planning & activities

Neoplasms codes have been expanded and capture more specificity than in ICD-9. This will help our healthcare system!
HIGH-LEVEL AWARENESS EDUCATION
CHECKLIST

Seek Resources on the ICD-10 transition. CMS and professional and membership organizations have developed information and resources to guide you through ICD-10 implementation.

Establish an ICD-10 Project Team. This team will be responsible for overseeing the ICD-10 transition, and will vary based on the size of your organization. Larger practices should have a team with representatives from different departments (e.g., executive leadership, physicians, and IT). Smaller practices may only have one or two individuals responsible for helping the practice make the switch to ICD-10.

Develop an ICD-10 Communication and Awareness Plan. This plan will map out how your organization will communicate with internal staff and external partners about ICD-10 throughout the transition.

Revisit and Revise Your Implementation Timeline. Since the ICD-10 compliance deadline is now October 1, 2014, your timeline for ICD-10 implementation activities will need to be updated.

Share Your Implementation Plans and Timelines. Discuss the new ICD-10 compliance deadline and share your revised implementation plans and timelines with internal staff and external partners to ensure transition activities are coordinated.

Share Best Practices and Lessons Learned: Communication and collaboration will help organizations as they transition to ICD-10.
CHECKLIST

Things to Do in the Future in the next few months
- Provide high-level training sessions for clinicians and coders and gradually move to more detailed training.
- Start testing ICD-10 codes and systems in your practice.
- Use ICD-10 codes along with ICD-9 codes for diagnoses you see most often.
- Check your data and reports for accuracy.
- Keep a pulse on your vendors and payers readiness.
- Begin testing ICD-10 codes in external operations (e.g., with partners such as payers, clearinghouses, and billing services).

Things to Do When the Deadline Hits
- Fully transition to ICD-10 on October 1, 2015, to stay compliant.
- Report ICD-9 codes for services provided before October 1, 2015.
- Report ICD-10 codes for services provided on or after October 1, 2015.
- Identify and correct errors as necessary.

ICD-10 REVIEW AND...

- ICD-10 Anxiety?
  - Loss of Productivity
  - Staff Shortage
  - Increased DNFB
  - Loss of Revenue
- Pressure
- Communications: clear and clean
- Provide assistance where needed
- PLAN:
  - Command Center for Go-Live
  - Systems issues
  - Patient issues and communications regarding claims
  - Closely monitor AR or DNFB/DNFC
  - Track CMI
  - Watch RAC Requests
  - Audit coding post go live
  - Re-educate
ACTION & NEXT STEPS

- 1. Review and Refresh your readiness
- 2. Budget for potential cash-flow impacts
- 3. Prepare for delayed payment and claims adjudication
- 4. Ensure you have open lines of communication
- 5. Deal with “Change Mgmt.”
- 6. Prepare for IT software updates, patches, conversion and testing
- 7. Adjust accounts receivable reserves as needed
- 8. Prepare for health information management (HIM) productivity delays and educational expense outlays
- 9. Ensure status reports from key operational areas are continuing
- 10. Use the free resources and tools available

SUMMARY

- ICD-10 can help our nation’s healthcare system
- Readiness
- Preparing
- Planning and DOING!
ICD-10 ADVOCACY

- Lots of swirl around implementation timeline
- Testimony 2/11/2015
- We need ICD-10 October 2015!

COALITION FOR ICD-10
HTTP://COALITIONFORICD10.ORG/
QUESTIONS/ANSWERS

- Are there any questions?

THANK YOU

- Gloryanne.h.bryant@sbcglobal.net
REFERENCES/RESOURCES

- Ahima.org
- CMS Road to 10: http://www.roadto10.org/
- CMS ICD-10 web site: http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
- USE THE ICD-10 DELAY TO YOUR ADVANTAGE; White Paper, 2014; Cindy Doyon, RHIA, Vice President Coding and Client Audit Services and West Strategic Sourcing Client, Precyse, Denise Johnson, RHIA, MS, CPHQ, Vice President, HIM Integrated Services, Precyse

REFERENCES/RESOURCES

- http://www.ahima.org/~media/AHIMA/Files/Certification/ICD10_CEU_FAQs.ashx
There are several online and instructor lead ICD-10 training options available for physician practices. Check with your affiliated hospital systems, medical societies, payers, clearinghouses, and associated professional organizations to see what types of training they have available. You can also find a list of training resources located under "ICD-10 Training" on the ceiling and Education Resources section of your AHIMA website.

ICD-11: Why doesn’t HHS skip over ICD-10 and implement ICD-11?

The history of updating the ICD system in the United States indicates that skipping directly to ICD-11 implementation could take too long. The World Health Organization published ICD-9 in 1978 and endorsed ICD-10 in 1990. The first draft of ICD-10-CH was released in 1995, but HHS did not propose the rule for ICD-10 adoption until 2008. The WHO is not slated to release ICD-11 until 2023. Based on the historical timelines of implementation, it will be 2039 until the United States is fully transitioned to ICD-11. It is also important to note that the gap between ICD-9 and ICD-10 is not nearly as large as the gap between ICD-9 and ICD-11. At this point in time, a transition directly to ICD-11 would be an even larger and more demanding undertaking for the healthcare industry.

Native coding means to assign an ICD-10 diagnosis code directly based on clinical documentation. Practices are encouraged to minimize code usage ICD-10 single diagnostic values instead of using Crosswalks, which should be used for general knowledge. Specific codes reflecting the most appropriate level of certainty known for an endoscopy should be elevated not specific diagnosis codes should be reported when they are supported by the available medical records relevant and clinical knowledge of the patient’s health condition.

If no definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definite diagnosis.

When sufficient clinical information is not present or available about a particular health condition to assign a more specific code, coding should comply with the payer guidelines for the use of unspecified codes.
**DOCUMENTATION TIPS**

- **NEOPLASMS**
  - Behavior:
    - Malignant (primary, secondary, in-situ)
    - Document any secondary sites
    - Benign
    - Unspecified behavior
    - Of uncertain histological behavior
    - Laterality (specify right/left)
  - Anatomical site (topography)
  - Other condition(s) associated with malignancy (dehydration, anemia, etc.)
  - Complication(s) associated with neoplasm
  - History of:
    - Has the malignancy been excised or eradicated?
    - Is there still treatment being provided for the primary and/or metastatic site?
  - Document any associated diagnoses/conditions

- **ANEMIA**
  - Documentation of Anemia should include the type of anemia:
    - Nutritional
    - Hemolytic
    - Aplastic
    - Due to blood loss
    - Other (please specify)
  - Include in documentation if Anemia is due to nutrition or mineral deficits, resulting in a nutritional anemia
  - Document if the Anemia is due to a neoplasm (primary and/or secondary)
  - Document whether the ANEMIA is “related to or due to” chemo or radiotherapy treatments
  - Document any “cause-and-effect” relationship between the intervention and the blood or immune disorder
  - Document the specific drug if anemia is drug-induced
  - Link any laboratory findings to a related diagnosis (if appropriate)
  - Document any associated diagnoses/conditions