ICD-10 in Real-Time: 
Today’s Knowledge is Tomorrow’s Success 

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Following this learning activity, participants will be able to:

- Identify best practice and potential obstacles of ICD-10 implementation
- Understand the need for high quality documentation required for ICD-10 success
- Describe best practices for how to begin and continue implementation efforts
Health Insurance Portability and Accountability Act (HIPAA) of 1996

- Administrative simplification set to standardize:
  - Privacy
  - Security
  - Electronic transactions and code sets
  - National identifiers
- HIPAA non-covered entities aren’t included so...
  - WORKERS COMP AND LIABILITY don’t have to comply by 10/1/2014
Why Replace ICD-9?

- It was developed in the 1970’s
- Technology and treatment has evolved
- Inability to compare cost and outcomes
- Is not supportive of interoperable information exchange
What is ICD-10?

**ICD-10-CM:**
Diagnosis codes which will be used by all providers in every health care setting

**ICD-10-PCS:**
Procedure codes which will only be used for inpatient hospital procedures

ICD-10 does not replace CPT®
• ICD-10-CM codes vary in length
• Unspecified codes are still an option, but should be used only if no other code exists
• Laterality, location, status, timing are concepts integral to the structure
Facts About ICD-10

- The compliance date is 10/01/2014
- Applies to all HIPAA-covered entities
- ICD-10 codes are more precise and provide better information and
  - Will enhance accurate payment for services rendered
  - Will help evaluate medical processes and outcomes
  - Will decrease the need to include supporting documentation with claims
Facts About ICD-10

• Documentation details needed for specified ICD-10 code selection are clinically relevant.

• ICD-10-CM was developed by the National Center for Health Statistics (NCHS), a division of the US Centers for Disease Control (CDC) with input from a variety of stakeholders including physicians, specialty societies, and more.
ICD-10-CM Structure

Category

Etiology, Anatomical Site, Severity

Extension
Key Concepts of ICD-10-CM

- Combination codes
- External cause codes
- Additional codes for added laterality
- Expanded codes
- Injuries by anatomical site
- Episode of care within descriptor
• A combination code is a single code used to classify:
  ▪ Two diagnoses, or
  ▪ A diagnosis with an associated secondary process (manifestation)
  ▪ A diagnosis with an associated complication
Combination Code Example

Diagnosis: Coronary artery disease of native coronary artery with unstable angina pectoris

<table>
<thead>
<tr>
<th>ICD-9 Codes</th>
<th>ICD-10 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>414.01 Coronary atherosclerosis of native coronary artery</td>
<td>I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris</td>
</tr>
<tr>
<td>411.1 Intermediate coronary syndrome</td>
<td></td>
</tr>
</tbody>
</table>
ICD-10-CM Concept: Etiology/Manifestation

• a.k.a. cause and effect relationship
• Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology
• “Code first” the underlying condition followed by manifestation
Hypertension vs Hypertensive

• Hypertension (HTN) is a separate disease process and may or may not be linked to another disease
  ▪ Exception: HTN with CKD = hypertensive chronic kidney disease

• Hypertensive represents a causal relationship between the HTN and the other disease process
  ▪ “Due to” or “because of”
SUBJECTIVE: The patient is a 78-year-old female who returns for recheck. She has hypertension and chronic heart failure. She denies difficulty with chest pain, palpations, orthopnea, nocturnal dyspnea, or edema.

OBJECTIVE: Vital Signs... General Appearance: She is an elderly female patient who is not in acute distress. Chest: Lungs are resonant to percussion. Auscultation reveals normal breath sounds. Heart: Normal S1 and S2 without gallops or rubs. Abdomen: Without masses or tenderness to palpation. Extremities: Without edema.

ASSESSMENT/PLAN: Hypertension and CHF. She is advised to continue with the same medication.
• I10 Essential (primary) hypertension
• I50.9 Congestive heart failure, unspecified
  -OR-
• I11.0 Hypertensive heart disease with heart failure
• I50.9 Congestive heart failure, unspecified
• Which option is best? Is a query needed?
ICD-10-CM Concepts: “and”, “or”, “with”

• “And” should be interpreted to mean either “and” or “or” when it appears in a title
  ▪ Example: K12.2 Cellulitis and abscess of mouth

• “With” should be interpreted to mean “associated with” or “due to”
  ▪ Example: K51.012 Ulcerative pancolitis with intestinal obstruction
ICD-10-PCS Structure

Section
Body System
Root Operation
Body Part
Approach
Device
Qualifier

Root Operation = Objective/Intent

(Med/Surg)
What does this mean to physicians?

Each selection is entirely dependent on documentation!

If it wasn’t documented with enough specificity- the physician will be asked to clarify!
What a Difference the Objective/Intent Makes

<table>
<thead>
<tr>
<th>Root Operation</th>
<th>Objective of Procedure</th>
<th>Site of Procedure</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insertion (H)</td>
<td>Putting in non-biological device</td>
<td>In/on a body part</td>
<td>Central line insertion Internal Fixation (w/o reduction)</td>
</tr>
<tr>
<td>Reposition (S)</td>
<td>Moving to normal location or suitable location</td>
<td>Some/all of a body part</td>
<td>Reduction displaced Fx (ORIF w/ device) Orchiopexy for undescended testes</td>
</tr>
</tbody>
</table>

- Internal fixation right radial fx
  - Insertion
  - 0PHH04Z
- ORIF right radial fx
  - Reposition
  - 0PSH04Z
## Comparing New Codes

<table>
<thead>
<tr>
<th>ICD-9 TODAY</th>
<th>ICD-10 in the FUTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis:</strong></td>
<td><strong>Diagnosis:</strong></td>
</tr>
<tr>
<td>320.1 Pneumococcal meningitis</td>
<td>G00.1 Meningitis, pneumococcal</td>
</tr>
<tr>
<td>481 Pneumococcal pneumonia [Streptococcus pneumoniae pneumonia] Lobar pneumonia, organism unspecified</td>
<td>J13 Pneumonia, pneumococcal</td>
</tr>
<tr>
<td><strong>Procedure:</strong></td>
<td><strong>Procedure:</strong></td>
</tr>
<tr>
<td>03.31 Spinal tap</td>
<td>009U3ZX—Puncture, See drainage,</td>
</tr>
<tr>
<td>Lumbar puncture for removal of dye</td>
<td>Drainage—spinal canal (009U)</td>
</tr>
<tr>
<td>Excludes:</td>
<td><strong>Excludes:</strong></td>
</tr>
<tr>
<td>lumbar puncture for injection of dye</td>
<td><strong>Excludes:</strong></td>
</tr>
<tr>
<td>[myelogram] (87.21)</td>
<td>lumbar puncture for injection of dye</td>
</tr>
<tr>
<td>[myelogram] (87.21)</td>
<td>[myelogram] (87.21)</td>
</tr>
</tbody>
</table>
Physicians will not use ICD-10-PCS codes for their own billing or reporting.

Physician documentation is required for accurate ICD-10-PCS code selection by facility.
Implementation Continuum

Assess
- Impact/Gap Analysis and Roadmap
- Scope

Design
- Project Plan (comprehensive)
- Budget
- Predictive financial analysis

Construct
- Perform upgrades, begin training
- Vendor management
- SME Development

Implement
- Integrated testing
- Intermediate/advanced Education

Operationalize
- Live in an I-10 world

Assess/Monitor
- Focus on productivity, margin, workflows

October 1, 2014

Where Are You on the Continuum?
Implementation Continuum

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Where Should You Be?

October 1, 2014
The Perfect Storm is Brewing...

Insurance Exchanges

RACs

ACOs

Value Based Purchasing

Health Information Exchange

Meaningful Use

Stage 2
Is ICD-10 in a Silo?

- How does the ICD-10 project align with an organization’s concurrent and future initiatives?
  - Executive Risk
- Are there overlapping requirements for Meaningful Use, ACO, RAC, other?
  - Can ICD-10 drive resource integration?
  - Enterprise wide data strategy?
  - Facilitation of common clinical language across practice locations?
ICD-9 lacks specificity and “interest”
- Physicians get paid based on CPT®

Should ICD-10 lack interest?
- ACOs
- RACs
- Meaningful Use
- Other payment initiatives
- Medical coverage policies
- Profiling
Recovery Audit Contractors (RACs)

- RAC Quarterly Report (October 1 – Dec 31, 2012)
  - $779.2 in “corrections” collected
  - “medical necessity” top issue in all 4 regions

Region C Cardiovascular Procedures:
“Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients undergoing cardiovascular procedures needs to be complete and support all services provided in the setting billed.”
Accountable Care Organizations (ACOs)

- Shift from “fee for service” to “risk” based payment
  - Based on delivery of care for less cost without reduction in quality
  - Focus on prevention and collaboration
- Requires “knowing your patient risk factors” and management of specific populations
  - ICD-9 Diabetes: 250.00 (DM without complication, type unspecified, not stated as uncontrolled)
    - Commonly reported for a significant % of diabetic patients
As EHR adoption has increased... discrete documentation has decreased

- Stage 1 attestation indicates
  - 75% of hospitals are not reconciling medications

- April 3, 2013 HIT policy committee hears testimony...(recommendations for Stage 3)
  - Move clinical documentation menu item to core in stage 3
  - Change E&M coding criteria to reduce over-reliance on specific language in clinical documentation
The “Common” Denominator

Tells the Patient Story

Quantitative Data

Supports Medial Necessity

Precise Documentation
Data Capture Challenges for Health Care Providers

- Multiple patients per day
- Numerous problems per patient
- Several treatment options per problem
- Various details needed to support medical necessity
“reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member.”

**SSA 1862(a)(1)**

“overarching criterion for payment in addition to the individual requirements of a CPT code.”

**CMS Claims Processing Manual 100-04**

“Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms...”

**American Medical Association**
Better Data is the “Answer”

Precise Documentation + ICD=10 = Better Data
Impact of Accuracy

- Data Integrity
- Quality of Care
- Communication
- Profile - Reflection
- Patient Safety
- Reimbursement
- Medical Necessity
The challenge is most physicians don’t realize:

- Coders shouldn’t assume anything
- Coders cannot use lab or x-ray findings alone
- Coders cannot use pathology findings alone
- Coders cannot interpret physician documentation to mean something simply because of experience
Diagnosis Details Needed Vary

- Type of disease or injury
- Acuity and severity
- With or without signs and symptoms
- Etiology and manifestation
- Due to medication or substance
- Laterality and anatomical location
- With or without complications
- External cause
Significant Change Areas

• Diabetes mellitus
• Injuries
• Drug under dosing*
• Cerebral infarctions
• AMI
• Neoplasms
• Musculoskeletal conditions
• Pregnancy
• Respiratory
Congestive Heart Failure (CHF)

- Systolic vs diastolic
- Left vs right
- Acute vs chronic

Example: **I50.21** Acute systolic (congestive) heart failure

Example: **I50.33** Acute on chronic diastolic (congestive) heart failure
CHF & DRGs

- I21.4 NSTEMI myocardial infarction
- I50.20 Systolic (congestive) heart failure (CC)
  - DRG 281 Relative Weight 1.1912

- I21.4 NSTEMI myocardial infarction
- I50.21 Acute systolic (congestive) heart failure (MCC)
  - DRG 280 Relative Weight 1.8503
Use
Using something for a purpose, habitually or regularly
i.e. Smoking cigarettes, chewing tobacco, social alcohol use, taking prescriptions

Abuse
Pattern of use that becomes harmful to the individual as well as others
i.e. Driving under the influence of drugs or alcohol

Dependence
Pattern of substance use where adverse consequences are accompanied by physical or psychological dependence on a substance
i.e. Alcoholism

Accurate Coding Supports Data Analytics, Population Health
Pt presented to the ED in the care of his brother who said that he is belligerent, hallucinating, and is high on cocaine, yet again. Brother is concerned for pt’s health and safety and wants him to be seen immediately to stop the cocaine abuse. Brother states patient has not been suicidal. Admit to rehab for detox and care. Follow up with psychiatrist for behavior modifications.

Impression: Cocaine abuse with hallucinations
<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>ICD-10-CM Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>292.12</strong> Drug-induced psychotic disorder with hallucinations</td>
<td><strong>T40.5x1A</strong> Poisoning by cocaine, accidental (unintentional), initial encounter</td>
</tr>
<tr>
<td></td>
<td><strong>F14.151</strong> Cocaine abuse with cocaine-induced psychotic disorder with hallucinations</td>
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</tbody>
</table>
There is no national requirement for mandatory ICD-10-CM external cause code reporting.

*Unless* a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of these codes is not required.

- Wisconsin Hospital Association requires reporting in some situations—be sure to watch for updates for hospital and ambulatory surgery center mandated data capture requirements.
Media hype comes from:

- **V91.07xA** Burn due to water-skis on fire
- **W22.02xA** Walked into lamppost
- **W58.13xA** Crushed by crocodile
- **W59.22xA** Struck by turtle, initial encounter
- **X52.xxxxA** Prolonged stay in weightless environment
- **W61.33xA** Pecked by chicken, initial encounter
- **Y92.72** Chicken coop (hen house) as the place of occurrence
Data analytics could really learn to appreciate:

- **V20.4xxA** Motorcycle driver injured in collision with pedestrian or animal in traffic accident
- **V47.61xA** Passenger of SUV injured in collision with fixed or stationary object in traffic accident
- **Y38.812A** Terrorism involving suicide bomber, civilian injured
- **W09.2xxA** Fall on or from jungle gym
- **Y92.210** Daycare center as place of occurrence
- **Y99.0** Civilian activity done for income or pay
Where to Focus Effort Today

- Stakeholder Readiness
- Testing
- Financial & Operational Neutrality
Who Do You Do Business With?

- payers, vendors, nursing homes, hospitals, referring physicians, DME suppliers, pharmacies, hospice, surgery centers, billing companies, clearinghouses...et al.

- Communicate early and often and establish a key contact that is responsive
- Review contracts/service agreements and assess potential cost and risk

- Collaboration is the **ONLY** option
Sample Questions

- What is your timeline for transition?
- What is your testing plan?
- What is your contingency plan?
- Are you using a crosswalk?
- Will you test with our organization?
- Will you provide any education?
# ICD-10 Timeline for Small-Medium Practices at a Glance

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
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<tr>
<td></td>
<td>Jan</td>
<td>Feb</td>
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<tr>
<td><strong>PLANNING</strong></td>
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<tr>
<td>Identify resources</td>
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<tr>
<td>Create project team</td>
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<tr>
<td>Assess effects</td>
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<tr>
<td>Create project plan</td>
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<tr>
<td>Secure budget</td>
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<tr>
<td><strong>COMMUNICATIONS</strong></td>
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<tr>
<td>Inform staff</td>
<td></td>
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<tr>
<td>Contact vendors</td>
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<td></td>
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<tr>
<td>Contact payers</td>
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<tr>
<td>Monitor vendor prep</td>
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<tr>
<td>Monitor payer prep</td>
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<tr>
<td><strong>TESTING</strong></td>
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<td>High-level training</td>
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<tr>
<td>for test team</td>
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<tr>
<td>Level 1: internal</td>
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<tr>
<td>Level 2: external</td>
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<tr>
<td><strong>COMPREHENSIVE TRAINING</strong></td>
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<tr>
<td>Documentation</td>
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<tr>
<td>Coding</td>
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<tr>
<td>Ongoing practice before “go live”</td>
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</table>

**DEADLINE: OCT 1, 2014**
Operational Testing Goals

• Operational neutrality:
  ▪ Ensuring clinical and business processes have been thoroughly tested for downstream success
    • Workflows, forms, registries, reports, registration, authorizations, business rules and edits, data, etc.

• Financial neutrality:
  ▪ Ensuring revenue neutrality is maintained across lines of business, payers, DRGs, etc.

• Clinical neutrality:
  ▪ Ensuring medical necessity requirements are clinically valid between I-9 and I-10
Common Industry Testing Terms

• Natively coded
  ▪ Not mapped, cross-walked or translated
    • “the old-fashioned” method of coding using books and guidelines

• Dual coded
  ▪ Patient record coded in both ICD-9 and ICD-10

• Direct testing
  ▪ Direct exchange of data between hospital or clinic and payer
Common Industry Testing Terms

• Scenario based testing
  Using sub-set of scenarios (not always medical record based) often provided by payer

• End to End testing
  Mimics production, simulates entire business cycle

• Asynchronous testing
  Non-linear testing with all stakeholders, typically using real medical record data
What is the Purpose of E2E Testing?

End-to-End testing is a focused process within a defined area, using new or revised applicable products, operating rules or transactions, *throughout the entire business and/or clinical exchange cycle*, for the purpose of *measuring operational predictability and readiness*. The End-to-End testing process should be performed in an environment *which mirrors actual production* as closely as possible, confirming the validation of performance metrics and analytics (reporting).

*Source: National Government Services, 2013*
Defining Your Test Data/Scenarios

- Financial and operational analysis of encounter data will drive testing scenario requirements

*Consider your data*

![Venn diagram showing Total % of Risk, Total Dx Codes, Unique Dx Codes, and Risk overlap.]

- Total % of Risk
- Total Dx Codes: 2000
- Unique Dx Codes: 300
- Risk: 300

*Image of Venn diagram with labels and numbers.*
Defining Your Test Data/Scenarios

- Analyze your data and use SMEs
  - High volume
  - High cost/revenue
  - High complexity (multiple points for failure)
    - Could be very low volume
  - Targeted opportunities for process improvement
  - Targeted opportunities based on contract review
    - P4P, Medicare Advantage HCC, Carve outs
Sample Key Performance Testing Indicators

- Coding accuracy
- Encoder accuracy
- Overall system functionality
- Billing accuracy
- Clearinghouse translation
- Payment accuracy
- Provider contract adherence
- Medical policy adherence
- HIPAA EDI compliance
Considerations:

- **Direct translations** (mapping, crosswalks, GEMS)
  - Uniformity and consistency
- **Payer coverage decisions**
  - Data is “power”, grace period length
- **Contracts**
  - DRG, P4P, quality measures
- **HIM, CDI and documentation impact**
Cash Flow Considerations

- Rejection rates may increase initially
- Claims may be pended for manual processing
- Payers may not be ready or have an unforeseen circumstance
- Decreased productivity
- Type of stakeholder dependency
- CMI
Managed Care Contracts

- Revenue impact and protection
- Cash flow impact and protection
  - Line of credit?
- Pay for performance and quality terms
- Claims adjudication edits
- Testing provisions
- Interest and timely filing
- Exit strategy
Identifying Future Risk

- Post October 1, 2014 surveillance
  - Contingency plan!
- Metric monitoring and intervention to improve when necessary
- Episodic payments
- Data, data, data
- Ongoing documentation improvement
- Staff retention
Questions?