ICD-10 Breakout Session

Conducting the Technology & Practice Impact Assessment
Your Presenter Today

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Content Of This Session

1. Technology Assessment
2. Practice Assessment
3. ICD-10 Coding Conventions
4. Some Planning Considerations
Acknowledgement

This content is the result of the collaboration of

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Part 1: The *Technology* Impact Assessment
Some Definitional Clarity

• Upgrade
  – A change to another (generally newer) version of your current vendor’s system
    • Some upgrades simply change your software, not your data, but
    • Changing to ICD-10 CM requires a change to your database

• Conversion
  – Generally, a change (a conversion) to a system manufactured by another vendor
Technological Options

1: “Local Hosting”
2: “ASP Service”
3: “Remote Hosting”
4: “Portal”

MSMSConnect / My1 HIE

EMRs
PMSs
Reg
Etc.

SSO Wins

Virtual CHC

Dr. Welby’s Office

Reliable Hosting Inc.

Yours
Others

Slide 7
Applications/Systems Potentially Impacted

- Locally hosted
  - PMS
  - EMR
  - Patient/Disease Registry
  - Patient Portal
Remote Hosted

- PMS – ASP/SaaS Provider
- EMR – ASP/SaaS Provider
- Disease Registry – ASP/SaaS Provider
- Patient Portal – ASP/SaaS Provider
- Physician Portal – ASP/SaaS Provider
- Health Information Exchange
- Ancillary Service Orders & Results
- Public Health Reporting Systems
- Medicare Claims (ANSI 5010)
- Medicaid Claims (ANSI 5010) plus CHAMPS changes
- Various payer systems
How To Begin To Get Information

• Getting info on your systems
  – Call your vendor, or VAR (Value-added Reseller) if you use one

• Getting info on other people’s systems that you use:
  – Call your ancillary services provider
  – Call your industry or professional association
  – Be sure to check out websites, but don’t forget a phone call
    • Doubly valuable with something this complex
    • After all you’ll need some contacts as you go down this road
Things To Be Sure to Cover

• Your vendor or VAR
  – Ask if they will be providing an upgrade to your product (the version you use) for you
  – Ask if the upgrade is to be included in your maintenance agreement, or whether you will have to pay for the upgrade
    • If you have not been paying maintenance for a while, you can expect to have to pay for the upgrade
  – If your product is quite a few years old, you should expect to have to purchase a wholly “new product” from your vendor.
    • This can entail the same complexity of work you’d face with a conversion to another vendor
Two Important Questions on that Upgrade

• Can it perform a straight automated change of your current database?
  – That is, it will not require any interventions by you as the update proceeds

• Can it convert diagnoses for your current patients?
  – If it won’t that’s not a total crisis, as you could perform a manual conversion yourself (or contract for it)
  – If it does a database conversion
    • Will they give you reports to assist you in validating the conversions?
    • How will it handle ICD-10 Codes that do not directly convert?
      – You want them to provide simple tables, lists, and the like that you can use to look up the proper ICD-10 Codes and make the changes
        » Don’t take their word here – get samples of reports
What If There Is No Update Possible?
(System too old, etc)

• If you have been increasingly frustrated with the system
  – This is the time to consider a total replacement, a modern, a (probably) easier system to use
  – A federally-certified system (the EMR/EHR side)
    • Will qualify you for the EHR Incentive
  – Newer systems are generally
    • 5010-ready
    • Use standard HL7 transaction sets

• If you love the system that has been with you all these many years, and don’t want to spend any more money....
  – Scream, or cry a little, because you are going to have to change to a new system
    • Not much different even if you “throw in the towel” and use the hospital’s system
Your System is Remote-Hosted?

- Will your supplier upgrade your software if the vendor offers an upgrade path?
  - Do those services include upgrading your ICD-9-based diagnosis codes in your patient records too?
- You can expect a special upgrade fee
  - One-time charge or an increase in your monthly fee
- If your supplier will NOT upgrade you to the ICD-10 version of your current vendor
  - Do they offer a conversion to other PMs/EMRs?
- If you have been unhappy with the software or your vendor’s services....
  - Is this the time to get a more satisfactory supplier and system?
Some Frequent Technology Considerations...
Interfaced EMR -> PMS?

• If you have a separate PMS and EMR that use an interface to share data between them
  – You may have to upgrade the interface, too
Federally ATCB-Certified EHRs OK?

- To date, the Stage 1 certification requirements do not specify ICD-10 capabilities
  - You will need to validate that their Stage 1 product handles ICD-10 Codes

- *Final* Stage 2 certification requirements specify ICD-10 capabilities
  - Stage 2 EHR products are just beginning to come on the market
Federally ATCB-Certified EHRs OK?
(con’t)

• 40 *Stage 2* EHRs certified on 4/17/13
  – Mostly modules
  – 4 complete solutions
    • Epic
    • Greenway
    • Meditech
    • NextGen
  – Expect additions on a nearly daily basis

Limit Concern to PMSs?

• It is true that billing and claims processing is the province of the PMS and is the major impact area for ICD-10 Codes, so....
  – Your current EMR might still meet your clinical documentation needs with the 09Codes, but
    • Final coding and claims submission in the PMS will then be a manual look-up process
    • P4P programs will involve manual coding
    • HEDIS reporting will involve manual coding
    • Incentive programs like PCMH will require manual reporting
    • Disease registries will require manual reporting
  – If you are a MU’er, you will likely have to complete an upgrade to continue to get your EHR incentive
Part 2
The Practice Impact Assessment
2 Main Areas Of Practice Activity

• Patient Care – Documentation
• Care Authorization & Billing/Claims
What Will Be The Impact?

• Perform an impact analysis of each step of the charge and payment process to see what will be impacted by the change.

• Doing it sooner rather than later, will
  – better ready you and staff for changes
  – also give you time to implement change management strategies that must accompany this conversion.
Preparation

• Some specific things to look at should include:
  – the super bill or charge ticket
  – compliance strategies in the central billing office (CBO)
  – payer contracts
  – vendor contracts
  – pre-AR charge editing software
  – coder responsibilities in the CBO
  – training for staff that will process charges
Preparation (cont’d)

• Specific things continued
  – clearing house edits
  – 5010 software should be operational with all carriers and clearinghouse.
  – impact on loading of insurance with shifts to MCR and MCD HMO plans
  – denial management - who is responsible?
  – interaction between offices and CBO
  – IT and CBO: who runs which part of the changeover?
The Encounter Form
Key Points To Keep In Mind

• The encounter form is a tool of communication.

• The encounter form will still have CPT codes as they currently have.
  – There are no changes at this time for CPT/HPCS codes.
Key Points To Keep In Mind (cont’d)

- ICD 10 will be impacting the DIAGNOSIS coding.
  1. Underlying patient condition(s); *all* relevant conditions
  2. Symptoms & signs when no confirmed diagnosis
  3. Indication of any history, sequelae, or stage of condition
  4. Indication of an impending or threatened condition
  5. Designation of side for any potential bilateral conditions
  6. Specify the service(s) provided during the encounter

  – REMEMBER: If it is not documented, IT DID NOT HAPPEN (Rule #1 for Auditors)
New Expectations For the EF

• Current encounter forms typically list the practice’s frequently used ICD-9 codes
• The encounter form will need to be updated which will make the encounter form more complex and lengthy
  – Where will you put all this information?
    • Diagnosis-specific forms as a solution?
  – How will you make this work?
  – What does this mean to billing staff?
Related Consequences

• Billing staff may need to be trained in physical systems to better understand how to code the encounter diagnosis
  – Reverting to “general codes” will be very bad idea

• Providers will need to be more definitive in their description of the diagnosis.
  – EXAMPLE:
    • Current: Dysphagia
    • ICD 10: Dysphagia, pharyngeal phase
Some Transition Considerations

• If you struggle in ICD 9 to indicate specificity, you will have greater challenges with ICD 10 since it is raising the bar.
  – One way to begin - create a chart listing of diagnosis and the ICD 10 documentation specificity needed to show that diagnosis
  – Changing your current encounter forms to list the appropriate ICD 10 codes that will be frequently used
  – Anticipate making updates to the form once you being using the using the ICD 10 codes
  – You may also want to consider implementing code selection software.
Impacts on Clinical Documentation
New Expectations For Documentation: Anatomical Specificity

• Providers need to list specific anatomy
  – EXAMPLE:
    • Cerebral infarction due to thrombosis of the left middle cerebral artery.

• Providers need to describe laterality
  – EXAMPLE:
    • Approximately 5,000 of the new codes have a RIGHT/LEFT distinction.
    • Central Corneal ulcer, right eye
In some cases, providers will need to document information for combination codes for conditions and common symptoms or manifestations.

- EXAMPLE:
  - Document ANY conditions that are related or causal
  - Diagnosis MUST be clearly documented
    - Atherosclerotic heart disease of native coronary artery with unstable angina pectoris.
New Expectations For Documentation (con’t)

• Providers will need to stress dominant vs non-dominant side
  – This will be for all paralytic syndrome codes such as hemiplegia, monoplegia and hemiparasis
  – EXAMPLE:
    • Previous cerebrovascular infarction 6 months ago with residual left sided hemiparasis on his dominant side.
New Expectations For Documentation: Etiology

• Providers need to state initial vs recurrent
  – Is the conditional at the initial onset or is this a recurrent condition?
    – EXAMPLE: Recurrent and persistent hematuria

• Some documentation issues will require providers to capture new information; others involve updated, modified, and otherwise expanded documentation needs.
Part 3
Concepts or Conventions Undergirding the ICD-10-CM Codes
Realities Around “GEMS”

• “Diagnosis Code Set General Equivalence Mappings” a/k/a “GEMS”
  – Are NOT a simple translational table to relate ICD-9 to ICD10 codes
    • New level of detail in ICD-10 means
      – Many individual 9 codes have multiple options in 10
    • Some 9 organizing concepts are no longer medically relevant
      – Some single 10 codes track back to many 9 codes
    • GEMS will perform significant amount of translation, but will also leave you plenty of conversions to do manually
    • GEMS is dynamic – there are periodic updates from the Coordination & Maintenance Committee

CMS Guidance:
<table>
<thead>
<tr>
<th>I-10 Description</th>
<th>Correlation</th>
<th>I-9 Description</th>
<th>Unequal Axis of classification</th>
</tr>
</thead>
<tbody>
<tr>
<td>O26.851 Spotting complicating pregnancy, first trimester</td>
<td>≠</td>
<td>649.50 Spotting complicating pregnancy, unspecified episode of care</td>
<td>Stage of pregnancy (I-10) vs. Episode of care (I-9)</td>
</tr>
<tr>
<td>O26.852 Spotting complicating pregnancy, second trimester</td>
<td></td>
<td>649.51 Spotting complicating pregnancy, delivered</td>
<td></td>
</tr>
<tr>
<td>O26.853 Spotting complicating pregnancy, third trimester</td>
<td></td>
<td>649.53 Spotting complicating pregnancy, antepartum</td>
<td></td>
</tr>
<tr>
<td>O26.859 Spotting complicating pregnancy, unspecified trimester</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
GEMS Drops Outdated Concepts

<table>
<thead>
<tr>
<th>I-9 contains</th>
<th>I-10 contains</th>
</tr>
</thead>
<tbody>
<tr>
<td>010.90 Primary tuberculous infection, unspecified examination</td>
<td></td>
</tr>
<tr>
<td>010.91 Primary tuberculous infection, bacteriological/histological exam not done</td>
<td></td>
</tr>
<tr>
<td>010.92 Primary tuberculous infection, bacteriological/histological exam unknown (at present)</td>
<td></td>
</tr>
<tr>
<td>010.93 Primary tuberculous infection, tubercle bacilli found by microscopy</td>
<td></td>
</tr>
<tr>
<td>010.94 Primary tuberculous infection, tubercle bacilli found by bacterial culture</td>
<td></td>
</tr>
<tr>
<td>010.95 Primary tuberculous infection, tubercle bacilli confirmed histologically</td>
<td></td>
</tr>
<tr>
<td>010.96 Primary tuberculous infection, tubercle bacilli confirmed by other methods</td>
<td></td>
</tr>
<tr>
<td></td>
<td>A15.7 Primary respiratory tuberculosis</td>
</tr>
</tbody>
</table>
Some Coding Considerations: Downside To Using General Codes

• Use caution in coding for “UNSPECIFIED”
  – There will be an “unspecified” code in ICD 10, and you can code it all you want.
  • Caution in 2-3 years when you review your severity and risk scores you won’t have the specificity in your codes to justify better FQHC rates/wrap arounds

• Some payers plan to reject any general or unspecific coding
  – Explanations must accompany such coding
Code Conventions – Clarity Around *Why* the Patient Sought Care

- ICD-10 codes now explain why the person sought medical attention.
  - Every diagnosis, disease, and condition has its own ICD-10 code.
  - For instance:
    - The ICD-10 code for adult onset diabetes without complications is E11.9
    - If there were complications, such as blindness, then there would be a different code (E11.3).
Code Conventions

• REMEMBER Key Factor for clinics:
  – Use the correct CPT/HCPS code with the **fee** not the rate
• Use the correct and MOST DETAILED diagnosis code
Code Conventions - The Role of Complications

• Specifications or complications of the general disease or condition (e.g., blindness associated with diabetes) are related to the baseline code for the disease or condition
Code Conventions: Code Structure

• For reporting purposes only actual codes are permissible, not categories or subcategories, and any applicable 7th character IS REQUIRED.

• The 7th character MUST ALWAYS be the 7th character in the data field. If a code that requires a 7th character is not 6 characters, a placeholder X must be used to fill in the empty characters.
  – Your 7th character must sit in the 7th place.
Code Conventions: Code Structure

• A code listed next to a main term is referred to as a default code.

• EXAMPLE:
  – If a condition is documented in the medical record (appendicitis) without any additional information, such as acute or chronic, the default code should be assigned.  *REMEMBER the impact in 2-3 years if this is the consistent practice of coding in the office.*
Type of Characters in the Codes

• First character is always alpha
• All the letters except U are used.
• Character 2 is numeric.
• Characters 3-7 can be alpha or numeric.
• Just as in ICD 9, there is a decimal after 1\textsuperscript{st} 3 characters.
Special Characters and Wording

• ICD 10 will utilize a placeholder character “X”
• The “X” is used as a placeholder at certain codes to allow for future expansion of the codes.
• Where a placeholder exists, the X must be used in order for the code to be considered a VALID code.
Special Characters and Wording (con’t)

• Abbreviations will still be used
  – NEC  Not elsewhere classifiable
  – NOS  Not otherwise specified

• Punctuation such as brackets and parentheses are used in the Alphabetic index and Tabular list to enclose supplementary words.
Special Characters and Wording (Con’t)

• When the term “and” is used in a narrative statement it represents and/or.

• “With” should be interpreted to mean “associated with” or “due to”

• “Other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist.

• “Unspecified” is used when the information in the medical record is insufficient to assign a more specific code.
Special Characters and Wording (con’t)

- “See” and “See Also” indicates that another term should be referenced.
- Go to the main term referenced in the “see” note to locate the correct code.
- “Code also note” instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction.
General Guidelines on Coding
How to Code: Finding the Code

- It will be essential to use BOTH the Alphabetic Index AND Tabular List when assigning a code.
- The Alphabetic Index does not always provide the full code.
- Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List.
How to Code: Finding the Code

• A 3 digit code is ONLY to be used if it not further subdivided.

• A code will be considered INVALID if it has not been coded to the full number of characters required for that code, including the 7th character, if needed
How to Code: Finding the Code

• A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required.

• If no dash is present, confirm through the use of the Tabular List to verify that no 7th character is required.
Code Selection Considerations

• EACH unique ICD 10 code may be reported only ONCE for an encounter. This applies to bilateral when there are no distinct codes identifying laterality or two different conditions to the same diagnosis code.
Code Selection Considerations cont’d

• Absent a confirmed diagnosis
  – Code signs and symptoms, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been confirmed by the provider.

• There can be situations calling for the use of combination codes.
  – Use combination codes only when that code identifies the conditions involved OR when the Alphabetic Index give direction to do so.
• Late Effects (Sequela)
  – There is no time limit on when a Sequela code can be used.
  – This usually required 2 codes.
    • The condition or nature of late effect is first
    • The sequela is second
  – Good example here is when a pregnancy becomes at-risk due to bleeding
• Impending or Threatened Condition
  – If it did occur, code as confirmed diagnosis
  – If it did not occur, determine if the condition is impending or threatened and reference main term entries
• Laterality
  – Always use the code showing laterality.
  – An unspecific code is also provided if the side is not identified in the medical record
  – If there is no bilateral code and the documentation indicates bilateral, assign separate codes for both the left and right side.
• BMI codes should only be reported as secondary diagnoses.

• Complications of Care
  – Code assignment is based on the provider’s documentation of the relationship between the condition and the care/procedure.

• HIV
  – Code only confirmed cases
Special Considerations for Frequent Conditions in General Practice

- Neoplasms
- Diabetes
- Chronic Pain
- Hypertension
- COPD
- Influenza
Special Considerations for Neoplasms

• Codes for most benign and ALL malignant neoplasms are available
• Some will be found in specific body system chapters.
Neoplasms, cont’d

- To properly code it will be necessary to determine from the record if the neoplasm is benign, in-situ, malignant, or of uncertain histologic behavior.

- If malignant, any secondary or metastatic sites should also be coded.
Special Considerations for Diabetes

• Codes are combination codes that include
  – The type of diabetes mellitus
  – The body system affected
  – Complications affecting that body system

• Assign as many codes as needed to identify all of the associated conditions the patient has.

• If the type of diabetes mellitus (Type I or 2) is NOT documented default to Type 2.
Diabetes, cont’d

• If documentation does not indicate the type of diabetes but does indicate the patient uses insulin, code Type 2
• Separate coding series for pregnancy and gestational diabetes
• Codes for underdose or overdose due to pump failure.
• Secondary diabetes due to underlying condition will have separate coding series
Special Considerations for Chronic Pain

• There is no time frame defining when pain becomes chronic.
  – The provider’s documentation should be used to guide use of these codes.
Special Considerations for Hypertension

• Hypertension with Heart Disease
  – Use an additional code to identify the type of heart failure in patient with heart disease

• Hypertension with Kidney Disease
  – If the patient has hypertensive chronic kidney disease and acute renal failure, and additional code for the acute renal failure is required.

• Hypertension, secondary
  – Secondary hypertension is due to an underlying condition.
  – Two codes are required:
    • One to identify the underlying condition
    • One to identify the hypertension
  – Sequencing of these codes is determined by the reason for the encounter.
Hypertension cont’d

• Hypertension, transient
  – Elevated blood pressure reading without diagnosis of hypertension, unless the patient has an established diagnosis of hypertension

• Hypertension, controlled
  – Refers to an existing state of hypertension under control by therapy.
  – Assign the appropriate code for hypertensive disease

• Hypertension, uncontrolled
  – May refer to untreated hypertension or hypertension that is not responding to current treatment.
Some Other Areas of Interest

• COPD and asthma
  – Codes will distinguish between uncomplicated cases and those in acute exacerbation. (worsening or de-compensation of a chronic condition)

• Influenza
  – Code only confirmed cases of influenza
  – If the provider documents “suspected”, “possible”, or “probable” code influenza due to unidentifiable influenza virus.
Notable New Factor

• Drug underdosing
  – This is a new code in ICD 10
  – It means that the patient has taken less of the medication than what was prescribed by the provider.
  – The medical condition will be listed FIRST and then the SECONDARY code will be the underdosing.
Part 4
Planning & Schedule Matters
Get Going!!!
Right Now?

• Commence parallel activity
  – High level planning
    • Sober up management
    • Select team
  – Begin talking with your IT solution vendors
  – Begin talking with your payers
    • Largest first – descending order
  – Discern impact on your typical diagnoses
  – Assess views and training needs of staff
General Advice

Do it in Stages!!
Key Target Dates

• Most key target dates are set by external parties
  – Software, new, or updates will be scheduled largely by your vendor or VAR
  – Claims filing testing windows will be set by your payer(s)
  – Cut-over date is set by CMS/HHS
When To Use ICD-10: Part 1

• ICD 10 is scheduled for October 1, 2014.
• There will be NO GRACE PERIOD on this implementation
• Services rendered on 10/1/14 and thereafter must be submitted using ICD 10 coding system.
• Services rendered before 10/1/14, regardless when filed, must be submitted using ICD 9 coding system.
When To Use ICD-10: Part 2

• If you have an INPATIENT and they were admitted BEFORE October 1, 2014 and they are discharged AFTER October 1, 2014 you will bill the ENTIRE inpatient billing under the ICD 10 coding system.
  – When the encounter finishes determines which code set is used
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