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Welcome to PMI’s Webinar Presentation

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Meet the Presenter…

On the topic:
Teaching Your Providers ICD-10

Pam Joslin
MM, CMC, CMIS, CMOM
Faculty
Practice Management Institute
Overview

– ICD Coding System
– ICD-10 Characteristics
– ICD-10 Implementation
– Clinical Documentation
– Sample Case

ICD CODING SYSTEM
ICD Coding Background

- Main purposes of disease coding
  - To assist in record retrieval
  - To produce statistics
  - Utilized for morbidity & mortality coding
    - Morbidity – codes are assigned from sources of information that relate to contacts for health services (e.g., medical records)
    - Mortality – codes are assigned from registrations of deaths
  - ICD is the global standard to report & categorize diseases, health-related conditions & external causes of disease & injury

The History of ICD-9

- 1938: ICD was published by the Health Organization of the League of Nations
- 1946: WHO accepted responsibility for the ICD and all subsequent revisions
- 1975: 9th revision was adopted
- 1977: National Center for Health Statistics (NCHS) developed the Clinical Modification of ICD-9
  - Expanded to 3 volumes
  - Introduced 5th digit
- 1988: April 1, Medicare Catastrophic Coverage Act required the use of diagnosis codes for Medicare reimbursement
Uses of ICD-9-CM Codes

- Tracking of disease processes
- Classification of causes of mortality
- Medical research
- Evaluation of hospital service utilization
- On insurance claim forms
- In the hospital inpatient setting for indexing purposes
- Calculation of Medicare hospital insurance payments (Prospective Payment Systems)

Worldwide Adoption of ICD-10

- January 1, 1999 – U.S. implemented ICD-10 for mortality (death certificates)
  - The only industrialized country not using ICD-10 for morbidity reporting
Why do we need a new coding system?

• ICD-9-CM is 30 years old and out of date
• Lacks sufficient specificity and detail
• Running out of capacity and limited structural design
• Obsolete
• Hampers the ability to compare costs and outcomes of different medical technologies
• Cannot support the US transition to an interoperable health data exchange
• ICD-9-CM limits the healthcare industry’s ability to improve its ability to provide patient care

HIPAA 5010 & ICD-10

• Preparation of ICD-10
  – HIPAA 5010
    • Federal mandate requiring replacement of HIPAA 4010A1 with 5010 electronic transaction standards
    • Every standard has been updated, from claims to eligibility to referral authorizations
    • All HIPAA covered entities will be affected
    • Requires transition from ICD-9 to ICD-10 code sets effective October 1, 2015
Benefits of Adopting ICD-10

- Greater coding accuracy and specificity
- Higher quality information for measuring healthcare service quality, safety, and efficiency
- Greater achievement of the benefits of an electronic health record
- Recognition of advances in medicine and technology
- Space to accommodate future expansion
- Increased ability to prevent and detect healthcare fraud and abuse
- Pay-for-performance programs
- Improved efficiencies and lower costs
- Reduced need for extra documentation describing patient’s condition, for reimbursement purposes

Benefit Analysis of Implementation

<table>
<thead>
<tr>
<th>Categories</th>
<th>Benefit ($Million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>More accurate payment for new procedures</td>
<td>100 - 1,200</td>
</tr>
<tr>
<td>Fewer rejected claims</td>
<td>200 – 2,500</td>
</tr>
<tr>
<td>Fewer fraudulent claims</td>
<td>100 – 1,000</td>
</tr>
<tr>
<td>Better understanding of new procedures</td>
<td>100 – 1,500</td>
</tr>
<tr>
<td>Improved disease management</td>
<td>200 – 1,500</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>700 – 7,700</strong></td>
</tr>
</tbody>
</table>
Impact of ICD-10 Implementation

• Increase in number of codes available

• Changes in software and information technology

• Greater specificity
  – Quality measurement and medical error reduction
  – May lead to changes in reimbursement patterns

• Complicated mapping

• Depends on:
  – Providers – more specific clinical information will require increased quality of medical record documentation
  – Coders – having a greater foundational knowledge of anatomy and physiology than needed to code in ICD-9-CM

(Conn, 2008)
ICD-10 CHARACTERISTICS

Overview of ICD-10

- ICD-10-CM Replaces ICD-9-CM Volume 1 and 2
- ICD-10-CM
  - Is built on the current ICD-9-CM coding system, with a few modified conventions and the incorporation of a new code format and nomenclature, or naming system.
  - Is an arrangement of similar diseases, and other conditions based on approved criteria.
  - Groups diseases in a variety of ways: etiology, anatomy, site, type of disease and morphology.
  - The most frequently used axis for most categories is anatomy.
**Comparison Between ICD-9 & ICD-10-CM**

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consists of three to five characters</td>
<td>Consists of three to seven characters</td>
</tr>
<tr>
<td>Approximately 13,000 codes</td>
<td>Approximately 68,000 codes</td>
</tr>
<tr>
<td>First character is numeric or alpha (E or V) or numeric, characters 2-5 are numeric</td>
<td>First character is alpha; Characters 2 &amp; 3 are numeric; Characters 4-7 are alpha or numeric (alpha digits are not case sensitive)</td>
</tr>
<tr>
<td>Always at least three characters</td>
<td>Flexible for adding new codes; Very specific</td>
</tr>
<tr>
<td>Decimal placed after the first three characters</td>
<td>Decimal placed after the first three characters</td>
</tr>
<tr>
<td>No Laterality</td>
<td>Has laterality</td>
</tr>
</tbody>
</table>

**ICD-10 Example**

- The addition of the 5th & 6th characters provide greater specificity
- Each ICD-10 code is complete, so there are no additional places to look for a continuation of the code, except for the extension character in the 7th position

ICD-10 Example: 

S64.4 Injury of nerves at wrist and hand level

- Category
- Extension: Postoperative manifestations
### Structural Differences:
Uses alphanumeric instead of numeric codes

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examples:</strong></td>
<td></td>
</tr>
<tr>
<td>496 – Chronic airway obstruction not elsewhere classified (NEC)</td>
<td>J44.9 – Chronic obstructive pulmonary disease, unspecified</td>
</tr>
<tr>
<td>088.81 &amp; 320.7 – Meningitis due to Lyme disease</td>
<td>A69.21 – Meningitis due to Lyme disease</td>
</tr>
<tr>
<td>813.81 – Closed fracture of the radius</td>
<td>S52.131A – Displaced fracture of neck of right radius, initial encounter for closed fracture</td>
</tr>
</tbody>
</table>
Preparing for the Transition

• Implementation Planning
  – Determine who will be responsible for leading the team through the transition
  – Implementation can be a smooth transition if you take a systematic approach
  – Many elements need to be addressed, but preparing your practice in a step-by-step fashion can keep the transition from becoming overwhelming
  – CMS recommends grouping the tasks into 6 phases:
    Phase 1 Planning           Phase 4 Implementation
    Phase 2 Communication and Awareness Phase 5 Testing
    Phase 3 Assessment          Phase 6 Transition

Preparing for the Transition

• Implementation Timeline
  – Each organization’s exact implementation process is unique
  – Identify tasks based on your organization’s specific business processes, systems, and policies
  – Identify critical dependencies
  – Identify resources and task owners
  – Estimate start dates and end dates
  – Continue to update the plan throughout ICD-10 implementation and afterwards
ICD-10 Implementation Schedule

- **PLANNING**
  - Identify Resources
  - Create Project Team
  - Create Project Plan
  - Assess Effects
  - Secure Budget

- **TESTING**
  - High Level Training for Test Team
  - Level 1: Internal
  - Level 2: External

- **COMMUNICATION**
  - Inform Staff
  - Contact Vendors/Payers
  - Monitor Vendors/Payers

- **COMPREHENSIVE TRAINING**
  - Documentation
  - Coding

Target Implementation Deadline: October 1, 2015

**Implementation Strategies**

- Risk and Issue Management
  - Perform a gap analysis
    - Identify risks by departments or key internal/external functions
      - Major focus areas: Technology, Finances and Documentation
    - Identify the chance a risk will occur, its degree of potential impact, and relevant ways to avoid risk
    - Develop strategies to streamline ICD-10 implementation
    - Assigns responsibility for risk reduction
    - Work with vendors and third parties to anticipate implementation issues and risks
    - Continuous monitoring
Implementation Strategies

• Budget Development for ICD-10
  – Commit to a multi-year plan and budget
  – Will require a structured, but flexible, budget that includes
    • Payer integration planning and modeling
    • Staffing costs
    • Training and education costs (for the entire organization)
    • Expenses associated with internal system changes and testing
    • Resource materials
    • Software updates
    • Superbill reprints and/or conversion to automated functionalities
    • Change management
  – Include contingency planning
  – Create funding reserves to help mitigate financial impact

Implementation Strategies

• Facility Assessment
  – The conversion to ICD-10 will affect how your practice handles many processes, from check in and scheduling to referrals and hospital admissions
    • Assess business and policy impacts
    • Analyze technological affects
    • Evaluate vendors
    • Review contracts for which payment is based on ICD-9-CM codes
    • Examine potential workflow changes
      – Analysis of coding and billing functions throughout the revenue cycle
      – Billing Forms/Spreadsheets
      – Clinical Documentation Issues
      – Impact on internal and external reporting
      – Quality of care
      – Cash flow disruption due to changing reimbursement models
Implementation Strategies

- ICD-10 Will Bring Some Significant Challenges
  - ICD-10 requires changes at the core of healthcare business, especially how patient care is documented.
  - Inadequate allocation of training and education resources.
  - Greater reimbursement losses due to ineffective clinical documentation.
  - Lack of compliance due to less than appropriate clinical documentation.
  - Poor clinical documentation can pose a higher risk due to more aggressive pursuit of fraud and abuse.

CLINICAL DOCUMENTATION
Documentation

- One major underlying issue with the dawn of ICD-10 is that many documenters do not think about or understand the relationship between their documentation and the billing process.
- Increased specificity of the codes will require changes in documentation practices.
- ICD-10 requires more details in clinical documentation for problems, assessments, procedures and treatments, as it relates to determining medical necessity, appropriateness of care, referrals, utilization, authorization and certification.

- Providers will need to document diagnoses with information about acuity, type, origin and manifestations to support severity and use of services for treatment of patient's specific disease process.
- Queries based on documentation requirements are expected to increase 10 to 50 percent.
  - Providers are expected to work load increase of 3-4 percent.
- Productivity losses among clinicians are expected to range from $50 million to $250 million before ICD-10 proficiency is achieved.
  - Prompt education on clinical documentation improvement may greatly reduce this estimate.
Some Changes Providers Will Need to Make in Documentation to Prepare for ICD-10 Coding

- Laterality
  - ICD-10-CM introduces laterality to diagnosis coding.

- Combination codes
  - ICD-10-CM greatly expands the use of combination codes, where a single code is used to classify two diagnoses or a diagnosis with an associated secondary process or complication.

- Episode of Care
  - ICD-10-CM relies more heavily on categorizing the episode of care for injuries and illnesses.

- Greater Specificity
  - ICD-10-CM is much more specific in identifying diseases and conditions and the documentation will need to reflect the exact diagnosis to take advantage of the improved granularity.

Laterality Example

- Example – Acute Otitis Media

- ICD-9-CM, we would have reported this with 381.00

- In ICD-10-CM, we would need to know which side and if it is acute, chronic or recurrent

- Documentation would have to demonstrate for example:
  - Patient has an acute onset of serous otitis media of the right ear, which is recurrent.
  - H65.04 – Acute serous otitis media recurrent, right ear
Combination Codes

- ICD-10-CM greatly expands the use of combination codes, where a single code is used to classify two diagnoses or a diagnosis with an associated secondary process or complication.
- This relationship cannot be assumed or inferred; the documentation must clearly state the relationship.
- Common example: Spondylosis with radiculopathy

```
M47.2 Other spondylosis with radiculopathy
M47.20 Other spondylosis with radiculopathy, site unspecified
M47.21 Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22 Other spondylosis with radiculopathy, cervical region
M47.23 Other spondylosis with radiculopathy, cervicothoracic region
M47.24 Other spondylosis with radiculopathy, thoracic region
M47.25 Other spondylosis with radiculopathy, thoracolumbar region
M47.26 Other spondylosis with radiculopathy, lumbar region
M47.27 Other spondylosis with radiculopathy, lumbosacral region
M47.28 Other spondylosis with radiculopathy, sacral and sacroccygeal region
```

Episode of Care

- ICD-10-CM relies more heavily on categorizing the episode of care for injuries and illnesses.
- ICD-10-CM features an expanded category for injuries:
  - A seventh character extension identifies the encounter type:
    - “A” for the initial encounter,
    - “D” for the subsequent encounter
    - “S” for sequela
• Greater Specificity
  – ICD-10-CM is much more specific in identifying diseases and conditions
  – The documentation will need to reflect the exact diagnosis to take advantage of the improved granularity
  – Specific in terms of anatomy or anatomical location of the disease or condition
  – For example: Dysphagia as the impression for a barium swallowing study (R13.1-)

• ICD-10 Documentation Issues by Condition – Hotspots
  – ICD-10 will magnify this necessity of precise clinical documentation, especially in the following categories:
    • Diabetes mellitus
    • Injuries – Fractures
    • Drug underdosing
    • Cerebral infarctions
    • AMI
    • Neoplasms
    • Musculoskeletal conditions
    • Pregnancy
S: Mrs. Smith presents today after having a shelf fall on her last week, suffering a concussion, as well as some cervicalgia. She was cooking dinner at the home. She did not seek treatment at that time. She states that the people that put in the shelving in her kitchen missed the stud by about 4 centimeters. Her husband, who was home with her at the time, told her she was “out cold” for about three minutes. The patient continues to have cephalgias since it happened, primarily occipital, extending up into the bilateral occipital and parietal regions. The headaches come on suddenly, last for long periods of time, and occur every day. They are not relieved by Advil. She denies any vision changes, any taste changes, any smell changes. The patient has a marked amount of tenderness across the superior trapezius.

O: Her weight is 188, which is up 5 pounds from last time; blood pressure 144/82; pulse rate 70; respirations are 18. She has full strength in her upper extremities. DTRs in the biceps and triceps are adequate. Grip strength is adequate. Heart rate is regular and lungs are clear.

A: Status post concussion with acute persistent headaches
  Cervicalgia
  Cervical somatic dysfunction

P: The plan at this time is to send her for physical therapy, three times a week for four weeks for cervical soft tissue muscle massage, as well as upper dorsal. We’ll recheck her in one month, sooner if needed.
ICD-9 | ICD-10
---|---
850.11 Concussion with loss of consciousness of 30 minutes or less | S06.0x1A Concussion with loss of consciousness of 30 minutes or less, initial encounter
339.21 Acute post traumatic headache | G44.311 Acute post traumatic headache, intractable
723.1 Cervicalgia | M54.2 Cervicalgia
739.1 Non-allopathic lesions of the cervical region | M99.01 Segmental and somatic dysfunction of cervical region
E916 Struck accidentally by falling object | W20.8xxA Struck by falling object (accidentally), initial encounter
E015.2 Activities involving cooking and baking | Y93.G3 Activity, cooking and baking
E849.0 Place of occurrence, home | Y92.010 Place of occurrence, house, single family, kitchen

Documentation is Under Scrutiny by Various Entities

- Peer Review Organizations (PROs)
- Medicare Administrative Contractors (MACS)
- Zone Program Integrity Contractors (ZPICs)
- Comprehensive Error Rate Testing Program (CERT)
- Medicaid Integrity Contractors (MICs)
- Recovery Audit Contractors (RACs)
  - FY 2010 RACs collected $92.3 million.
  - FY 2011 RACs corrected $934.9 million.
    - Collected in overpayments $797.4 million
    - Identified underpayments $141.9 million returned to providers
    - Returned to the Medicare Trust Fund $488.2 million
Perform a Gap Analysis on Documentation

- Gap analysis is a tool that helps offices compare actual documentation performance with potential documentation performance.
  - It addresses two questions:
    - “Where are we?”
    - “Where do we want to be?”
  - Focus on coding and clinical documentation practices.
  - Analyze ICD-9 frequency data.
    - Determine the 50 most frequently billed ICD-9 codes.
    - Facilitate educational efforts on most frequently coded conditions.

Documentation Analysis

- The most effective way to ensure that documentation will meet the requirements of ICD-10
- Offer appropriate education to providers so when ICD-10 is implemented, they will already be documenting to ICD-10 standards, making the transition seamless.
- Random samples should be evaluated and various types of medical records reviewed.
- Audits should be conducted by experienced auditors.
- Use a clinical documentation assessment tool to be sure current documentation adequately supports ICD-10:
  - Continue to focus on coding and clinical documentation practices.
  - Identify medical record documentation improvement opportunities.
  - Develop a priority list of diagnoses requiring more detail.
  - Identify providers who will benefit from focused training using ICD-10-CM.
Key Points to Remember

• Documentation is critical in the appropriate selection of E&M services and in the ultimate reimbursement for all services rendered to patients.

• If providers are not documenting concisely for reimbursement, they are putting themselves at unnecessary risk for not supporting medical necessity.
  – Medical necessity of a service is the principal criterion for payment in addition to the individual requirements of a CPT® code.
  – The volume of documentation should not be the primary influence upon which a specific level of service is billed.
  – Documentation should support the intensity of patient evaluation and treatment level of service.

Key Points to Remember

– Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider—both under ICD-9, as well as in ICD-10.

– For successful implementation of ICD-10, it is important to help providers understand what steps need to be taken.

– Successful implementation involves engaging providers as successful partners in making the transition to ICD-10.

– Remember: Clinicians must provide greater medical record documentation to support more detailed codes.
Changes to Superbills

• To illustrate the added complexity that providers may face when using ICD-10:
  – BCBS converted the model “superbill” created by the American Academy of Family Practitioner’s practice management journal from ICD-9 to ICD-10
    • The superbill goes from 2 pages to 9 pages
    • This is a mockup and is not intended to be considered as a final superbill — it illustrates what providers may need to use to code accurately under ICD-10.

Bottom Line

The greater specificity in ICD-10 codes will require a more discerning coder and thorough clinical documentation from the provider, which will ultimately improve patient care.
Summary

• The Provider is the Key.
  – Preparation is essential – Failure to prepare will cost you money.
  – Assign a team leader.
  – Develop a plan of action.
  – Create a budget.
  – Conserve funds.
  – Establish incremental goals/timelines.
  – Communicate/coordinate with vendors.
  – Perform chart audits.
  – Identify your 50 most frequently used ICD-9 codes & create ICD-10 crosswalks.
  – Engage in education and training.

Will you be ready?

Web Resources

– CMS
  • General ICD-10 Information
    – http://www.cms.hhs.gov/ICD10
  • ICD-10 Notice of Proposed Rulemaking
  • ICD-10-CM Coding System
    – http://www.cms.hhs.gov/ICD10/03_ICD_10_CM.asp#

– CDC
  • Complete Versions of ICD-10 and general equivalence mappings may be found at:
    – http://www.cdc.gov/nchs/icd/icd10cm.htm
  • General ICD-10 information
    – http://www.cdc.gov/nchs/icd.htm

Note: Website addresses subject to change
Tips, Tools, and Techniques

1. Get your implementation team together.

2. Identify top codes to crosswalk to ICD-10.

3. Review documentation and prepare for improvements to protect your revenue.

Questions?

• Pam Joslin, MM, CMC, CMIS, CMOM
• Faculty, Practice Management Institute
• pjoslin@pmiMD.com

Thank you for your attendance!

Get your questions answered on PMI’s Discussion Forum: http://www.pmiMD.com/pmiForums/rules.asp
References


Developed by: Audrey E. Coaxum,
CHI, CPC, CMC, CMIS, CMOM, CMCO
Faculty/Consultant, Practice Management Institute

Updated by: Pam Joslin
MM, CMC, CMIS, CMOM
Faculty, Practice Management Institute