Countdown to ICD-10

August 27, 2015

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Agenda

- National Implementation Update – CMS Acting Administrator Andy Slavitt

- Preparing for ICD-10: Coding and Documentation – Sue Bowman, AHIMA and Nelly Leon-Chisen, AHA

- Medicare FFS Claims Processing, Billing, and Reporting Guidelines for ICD-10 – Felicia Rowe, CMS

- CMS and AMA Joint Announcement – CMS Chief of Staff Mandy Cohen

- FFS Medicare Testing Plan for ICD-10 Success – Stacey Shagena, CMS

Preparing for ICD-10: Coding and Documentation

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Who Is Affected by the ICD-10 Transition?

- ICD-10-CM (diagnoses) will be used by all providers in every health care setting

- If you are currently required to report ICD-9-CM **Diagnosis** codes, you will transition to ICD-10-CM on October 1, 2015

Who Is Affected by the ICD-10 Transition?

- ICD-10-PCS (procedures) will be used only for hospital claims for inpatient hospital procedures
  - ICD-10-PCS will not be used on physician claims, even those for inpatient visits

- No impact on use of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes
  - CPT and HCPCS will continue to be used for physician and outpatient services including physician visits to inpatients

Who Is Affected by the ICD-10 Transition?

- If you are currently required to report ICD-9-CM **Procedure** codes, you will transition to ICD-10-PCS on October 1, 2015

- If you do **not** currently report ICD-9-CM procedure codes, your procedure coding system will not change

Date of Service is Key Driver

- Determination of which code set to use is driven by date of service, **not** billing date
  - Date of service for outpatient and physician reporting
  - Date of discharge for inpatient facility reporting

- Claims for dates of service **on and after** October 1, 2015 **must be coded in ICD-10**

- Claims for dates of service **prior to** October 1, 2015 **must be coded in ICD-9**

Date of Service is Key Driver

Examples:
Patient visit to physician office on September 30, 2015 – ICD-9

Patient visit to physician office on October 1, 2015 – ICD-10

Claim submission date is irrelevant to determining which code set to use – if a claim is submitted after October 1 for a date of service prior to October 1, ICD-9 codes (and no ICD-10 codes) should be reported

Reminder – for inpatient facility reporting, "date of service" is defined as date of discharge

Date of Service is Key Driver

- No claim can contain both ICD-9 and ICD-10 codes

- CMS has provided [guidance](#) on how to handle claims that span the October 1 transition date

- No dual code reporting – any claims for dates of service after October 1, 2015 that contain ICD-9 codes will be rejected

Medicare Payment Impact of Transition

- Physician claims: In general, Medicare Administrator Contractors (MACs) will use ICD-10-CM codes to determine coverage, not to determine amount CMS will pay for furnished services

- Hospital inpatient claims: MACs will use ICD-10-CM and ICD-10-PCS codes to assign discharges to appropriate ICD-10 MS-DRGs

Source: [CMS ICD-9-CM, ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets Educational Tool](#)

No Change in Diagnosis Coding Process

- Process for determining correct code is same as ICD-9
  - Look up diagnostic term in Alphabetic Index, then
  - Verify code number in Tabular List

- To be valid, ICD-10-CM diagnosis codes must be coded to the full number of characters required for that code.

- [Complete list of ICD-10-CM valid codes and code titles](#) - zipped file is called icd10cm_codes_2016.txt

- This list should assist providers who are unsure as to whether an additional 4th, 5th, 6th, or 7th, character is needed for a code to be valid.

Valid vs. Invalid Codes

- Examples of invalid/incomplete/truncated codes
  These codes are invalid because all codes in S02 require 7 characters to be valid:
  S02
  S02.6
  S02.60
  S02.609

- Only codes in a few chapters require 7th characters

- Are these codes valid or invalid?
  E10 (invalid)

  E10.2 (invalid)
  E10.21 (valid)

  E10.31 (invalid)
  E10.311 valid)

  I10 (valid)

Valid vs. Invalid Codes

- Coding, billing and claims editing programs may have flags to identify invalid codes

- Code books may identify invalid codes in the Tabular List using a variety of formats
  - Color coding
  - Flags
  - Symbols
  - Hyphens

Unspecified Codes Still Acceptable

- While documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when documentation doesn't support a higher level of specificity

- Unspecified codes have acceptable, even necessary, uses

- When sufficient clinical information isn't known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate "unspecified" code

Unspecified Codes Still Acceptable

- It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code

- Part of the *ICD-10-CM Official Guidelines for Coding and Reporting*, which all HIPAA-covered entities must comply with

Common Unspecified Codes

- Anemia
  - *ICD-9: 285.9*
  - *ICD-10: D64.9*
- Abdominal pain
  - *ICD-9: 789.00*
  - *ICD-10: R10.9*
- Stroke
  - *ICD-9: 434.91*
  - *ICD-10: I63.9*
- Angina
  - *ICD-9: 413.9*
  - *ICD-10: I20.9*
- Chronic obstructive pulmonary disease
  - *ICD-9: 496*
  - *ICD-10: J44.9*

Unspecified Code Example

Patient seen by family practitioner for hay fever; patient also has Hodgkin's lymphoma being treated by another physician (family practitioner does not have more specific details regarding type and site of Hodgkin's lymphoma)

Codes: J30.1, Allergic rhinitis due to pollen
C81.90, Hodgkin lymphoma, unspecified, unspecified site

ICD-10-CM Coding Examples

Type 2 diabetes mellitus

Step 1

Look up term in Alphabetic Index:

Diabetes, diabetic (mellitus) E11.9

      type 2 E11.9

ICD-10-CM Coding Examples

Type 2 diabetes mellitus (continued)

Step 2

Verify code in Tabular:

E11 Type 2 diabetes mellitus

      E11.9 Type 2 diabetes mellitus without complications

      Code Assignment: E11.9

ICD-10-CM Coding Examples

Carpal tunnel syndrome, right side

Step 1

Look up term in Alphabetic Index:

Syndrome

       carpal tunnel G56.0-

ICD-10-CM Coding Examples

Carpal tunnel syndrome, right side (continued)

Step 2
Verify code in Tabular:
G56 Mononeuropathies of upper limb

      G56.0- Carpal tunnel syndrome

            G56.00 Carpal tunnel syndrome, unspecified upper limb

            G56.01 Carpal tunnel syndrome, right upper limb

            G56.02 Carpal tunnel syndrome, left upper limb

Code Assignment: G56.01

Prepare Now

5 key steps:*

1. Make a plan
2. Train staff
3. Update processes
4. Talk to your vendors and health plans
5. Test systems and process

There is still time to prepare, but you need to get started

*Source: CMS ICD-10 Quick Start Guide

How to Obtain a Code Book

- Free ICD-10-CM code set from the Centers for Disease Control and Prevention

- Code books and associated tools with helpful hints from many commercial vendors
  - Paper
  - Electronic
  - Mobile apps

Increasing Demand for High-Quality Documentation

- High-quality documentation provides more accurate clinical picture of quality of care provided

- Better clinical documentation promotes better patient care and more accurate capture of acuity, severity, and risk of mortality
  - Quality and performance reporting
  - Reimbursement
  - Severity-level profiles
  - Risk adjustment profiles
  - Provider profiles
  - Present on admission reporting
  - Hospital-acquired conditions

Clinical Documentation & ICD-10

- Increased specificity of ICD-10 codes requires more detailed clinical documentation

- ICD-10-PCS does **not** require procedures to be documented in ICD-10-PCS terms

  Per [ICD-10-PCS Official Guidelines for Coding and Reporting](#): Many of the terms used to construct PCS codes are defined within the system. It is the coder's responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear.

Documentation Assessment & Improvement

- Current documentation practices should be assessed
  - Target most common diagnoses
  - Code record sample in ICD-10
  - Identify documentation gaps

- Resolve documentation gaps
  - Leverage technology to capture documentation at point of care
    - Electronic Health Record (EHR) documentation templates
    - EHR prompts
  - Modify forms or templates
  - Education
  - Workflow or operational process changes

AHA Central Office

- Clearinghouse service established by 1963 Memorandum of Understanding with Department of Health and Human Services to provide **free** assistance with ICD-9-CM advice
  - Since 2014 converted to solely providing ICD-10-CM and ICD-10-PCS coding advice
  - Does not replace learning how to code

How to Submit a Coding Question?

- Questions should be submitted via www.codingclinicadvisor.com
  - Not limited to AHA members, but registration required

- Review FAQ section for details on how to submit questions (same process was used for ICD-9-CM questions)
  - Formulate coding question, not just "what is the code for XYZ"
  - Provide documentation
  - Specify whether inquiry refers to a certain setting (e.g. skilled nursing facility, home health, etc.)
  - Cannot answer questions on payment, coverage, etc.

AHA Coding Clinic

Quarterly publication provided ICD-9-CM coding advice for over 30 years

- 2012-early 2014 Dual ICD-9-CM and ICD-10-CM and ICD-10-PCS advice

- Since early 2014 solely focused on ICD-10-CM and ICD-10-PCS

- Practical examples of frequently asked questions from AHA Central Office clearinghouse service

- Real life applications of classification rules and guidelines

- Fills in gaps on code selection

AHA Coding Clinic

Supported by the Editorial Advisory Board:

- Centers for Medicare & Medicaid Services
- Centers for Disease Control National Center for Health Statistics
- American Hospital Association
- American Health Information Management Association
- American Academy of Pediatrics
- American Medical Association
- American College of Physicians
- American College of Surgeons
- Other physician specialties on ad hoc basis
- Coding experts

In Summary

- ICD-10-CM (diagnoses) will apply to all healthcare providers for services effective October 1, 2015

- Unspecified codes have acceptable, even necessary, uses
  – Code to level of specificity known for that encounter

- ICD-10-PCS (procedures) will **only** apply to hospitals reporting inpatient procedures
  – If you currently report CPT/HCPCS codes, there is no change

Learn the Basics

- CMS provider "ICD-10 Basics" MLN Connects Calls/Videos:
  - ICD-10 Basics Call
  - More ICD-10 Basics Call
  - ICD-10 Coding Basics Video
  - Coding for ICD-10-CM: More of the Basics Video

- CMS and AHIMA ICD-10 Clinical Documentation Improvement webinar

- CMS ICD-10 Quick Start Guide

Links

- [ICD-10-CM code set - PDF file](#)

- [ICD-10-PCS code tables, index, and related files](#)

- [ICD-10-CM Official Guidelines for Coding and Reporting](#)

- [ICD-10-PCS Official Guidelines for Coding and Reporting](#)

AHIMA ICD-10 Resources

www.ahima.org/icd10

- Clinical Documentation Training for ICD-10 by Specialty (online program)

- Physician Practice ICD-10 Implementation Model

- ICD-10 Documentation Tips

- ICD-10 Implementation Toolkit

- ICD-10 Preparation Checklist

AHA ICD-10 Resources

- [Coding Clinic for ICD-10-CM and ICD-10-PCS](#)
- [Free coding webinars](#), including *Best of Coding Clinic*
- *ICD-10-CM and ICD-10-PCS Coding Handbook*
- ICD-10 Implementation Executive Briefing
- [Monthly Blog](#) on ICD-10 Implementation, in partnership with the College of Healthcare Information Management Executives - perspectives from CEO, CIO and CMO

Claims Processing Systems

- ICD-10 Formats for diagnosis and procedure code field size expansions completed with the transition to version 5010 for electronic HIPAA compliant claims

- Medicare Fee-For-Service (FFS) claims processing systems ready for ICD-10 since October 2013

- Medicare FFS converted over 200 internal systems edits

Claim Submission

- ICD-9 codes no longer accepted on claims for dates of service on or after October 1, 2015

- ICD-10 codes will not be recognized/accepted on claims for dates of service before October 1, 2015

- Claims cannot contain both ICD-9 codes and ICD-10 codes

- No Dual Processing

- Claims that do not meet these standards will be returned to provider (institutional claims) or returned as unprocessable (professional/supplier claims)

Claims that Span October 1, 2015

- Inpatient claims
  - Select code set based on the THROUGH/discharge date
  - For span dated claims, use ICD-10

- Outpatient claims
  - Split claims
  - Select appropriate code set based on the FROM date of service

- Professional and supplier claims, including Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
  - Select code set based on the FROM date of service

Useful Billing Guidance

- [MLN Matters Special Edition Article SE1325](#), "Institutional Services Split Claims Billing Instructions for Medicare FFS Claims that Span the ICD-10 Implementation Date"

- [MLN Matters Special Edition Article SE1408](#), "Medicare FFS Claims Processing Guidance for Implementing ICD-10 – A Re-Issue of MM7492"

- [MLN Matters Special Edition Article SE1410](#), "Special Instructions for ICD-10 Coding on Home Health Episodes that Span October 1, 2014"

- [ICD-10-CM/PCS Billing and Payment Frequently Asked Questions](#) Fact Sheet

CMS and AMA Joint Announcement

Dr. Mandy Cohen, M.D., MPH

Chief of Staff

Office of the Administrator, CMS

MLN Connects®

Transition Flexibility

- For 12 months after ICD-10 implementation, if a valid ICD-10 code from the <u>right family</u> is submitted, Medicare will process and not audit valid ICD-10 codes.
  - In certain circumstances, a claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations.

- For all quality reporting completed for program year 2015, Medicare will not subject physicians or other Eligible Professionals (EP) to the Physician Quality Reporting System (PQRS), Value Based Modifier (VBM) , or Meaningful Use (MU) penalties during primary source verification or auditing related to the additional specificity of the ICD- I0 diagnosis code, as long as the physician/EP used a code from the <u>correct family of codes</u>.
  - An EP will not be subjected to a penalty if CMS experiences difficulty calculating the quality scores for PQRS, VBM, or MU due to the transition to ICD-I0 codes.

- These flexibilities are for physicians and other practitioners whose claims are billed under the part B physician fee schedule.

"Family" of Codes

- Family of codes" is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition.

- Example: Crohn's disease: K50
  – To include the Crohn's disease diagnosis on the claim, a valid code must be selected. As long as the selected valid code was within the K50 family, then the audit flexibility applies.
- Examples of valid codes within category K50 include:
  – K50.00 Crohn's disease of small intestine without complications
  – K50.012 Crohn's disease of small intestine with obstruction
  – K50.90 Crohn's disease, unspecified, without complications

FFS Medicare Testing Plan for ICD-10 Success

Stacey Shagena, Technical Advisor

Medicare Contractor Management Group

Center for Medicare, CMS

Four-Pronged Approach

1) Internal testing of CMS claims processing systems

2) Provider-initiated beta testing tools

3) Acknowledgement testing

4) End-to-end testing

Provider-Initiated Beta Testing Tools

- National Coverage Determination (NCD) / Local Coverage Determination (LCD) conversions to ICD-10

- Medicare Severity Diagnosis Related Group (MS-DRG) conversion project

- Integrated Outpatient Code Editor

- [MLN Matters Special Edition Article SE1409](#)

Acknowledgement Testing

- Began in March 2014

- Available through September 30

- Four special weeks completed

Acknowledgement Testing Results

Summary of Special Testing Weeks:

- Almost 5,000 submitters
- Nearly 160,000 claims
- National acceptance rate ranged from a low of 76% in November 2014 to a high of 91.8% in March 2015
- No Medicare FFS claims systems issues
- Rejections largely due to Issues unrelated to ICD-10

End-to-End Testing

- Submission of test claims and receipt of RA from Medicare
- First time this type of testing was offered to providers
- Three testing periods in 2015: January, April, and July
- Up to 50 submitters selected from each MAC jurisdiction
- Testers were chosen from volunteers
- Testers could submit up to 50 claims

End to End Testing Results: July 2015

- Final end to end testing opportunity

- July testing results – the numbers

- No system problems found

CMS Resources

ICD-10 Website

- [ICD-10](#) website: Latest information and links to resources for providers to prepare for implementation:
  - [Road to 10](#)
  - [Quick Start Guide](#)
  - CMS/American Medical Association (AMA) joint announcement, guidance, FAQs
  - Videos, fact sheets
  - Sign up for [Industry Email Updates](#)

- [Provider Resources](#) web page: Educational resources and information for all providers

- Free coding resources:
  - [2016 ICD-10-CM and General Equivalency Mappings](#)
  - [2016 ICD-10 PCS and General Equivalency Mappings](#)

ICD-10 Website

- [Medicare Fee-For-Service Provider Resources](#) web page: Medicare Learning Network educational materials:
  - MLN Matters Articles
  - Medicare Learning Network Web Based Training Course
  - Medicare Learning Network Products
  - MLN Connects Videos
  - CMS Resources

- [CMS Sponsored ICD-10 Teleconferences](#) web page: Access materials from previous MLN Connects Calls, including video slideshow presentations

National Coverage Determinations

- NCDs are those decisions made by CMS and applied by each MAC at a national level
- NCDs and ICD-10: CMS has translated all appropriate NCDs, updated system edits (completed October 2014) and published the translations on the [National Coverage Determination Conversion Information](#) web page
- Information on NCD translations are communicated through CMS transmittals and MLN Matters Articles
- Send inquiries about NCD translations to CAGinquiries@cms.hhs.gov with ICD-10 in the subject

Local Coverage Determinations

- LCDs are those decisions made by the individual MAC and are usually jurisdictionally based.
- Each MAC is responsible for converting the ICD-9 codes to ICD-10 codes in their LCDs.
- MACs completed the translations for existing LCDs in April 2014. They can be found on the MAC websites or on the CMS website (use index to find MAC of interest, and click on "future date LCD").
- MAC Contact Information for Questions about LCD Translations

Question & Answer Session

ICD10-National-Calls@cms.hhs.gov

Acronyms in this Presentation

- AHA: American Hospital Association
- AHIMA: American Health Information Management Association
- AMA: American Medical Association
- CPT: Current Procedural Terminology
- DMEPOS: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
- EHR: Electronic Health Record
- EP: Eligible Professional
- FFS: Fee-For-Service
- HCPCS: Healthcare Common Procedure Coding System
- LCD: Local Coverage Determination
- MAC: Medicare Administrator Contractor
- MS-DRG: Medicare Severity Diagnosis Related Group
- MU: Meaningful Use
- NCD: National Coverage Determination
- PQRS: Physician Quality Reporting System
- RA: Remittance Advice
- VBM: Value Based Modifier

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