Navigating a Smooth Transition to ICD-10-CM

Tricia A. Twombly BSN RN HCS-D HCS-O COS-C CHCE
AHIMA Approved ICD-10 CM Trainer
AHIMA Ambassador

Objectives

• Discuss differences between ICD-9-CM and ICD-10-CM
• Analyze the impact on the home health industry
• Discuss readiness of the home health industry
• Analyze coding team responsibilities
• Discuss importance of clinical documentation
• Identify transition timeline
History ICD-9

- World Health Organization (WHO) developed ICD-9 for worldwide use
- U.S. developed clinical modification (ICD-9-CM)
- Implemented in U.S. in 1979
  - Expanded number of diagnosis codes
  - Developed procedure coding system
History ICD-9

• ICD-9-CM is used to:
  - Calculate payment
  - Adjudicate coverage
  - Compile statistics
  - Assess quality
  - Risk adjustment
  - Outcomes

History ICD-9

• System is 30 years old
• Many categories are full
• Not descriptive enough
• Outdated medical terms
• New technologies are not included
### Comparison of ICD-9-CM and ICD-10-CM Diagnosis Codes

<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes</th>
<th>ICD-10-CM diagnosis codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited space for adding new codes</td>
<td>Flexible for adding new codes</td>
</tr>
<tr>
<td>Lacks detail</td>
<td>Very specific</td>
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<tr>
<td>Lacks laterality</td>
<td>Has laterality</td>
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<tr>
<td>Difficult to analyze data due to non-specific codes</td>
<td>Specificity improves coding accuracy and richness of data for analysis</td>
</tr>
<tr>
<td>Codes do not adequately define diagnoses needed for medical research</td>
<td>Detail improves the accuracy of data used for medical research</td>
</tr>
<tr>
<td>Doesn’t support interoperability with other countries</td>
<td>Supports interoperability with other countries</td>
</tr>
</tbody>
</table>

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### Why ICD-10?

- Monitoring resource utilization
- Improving clinical, financial, and administrative performance
- Preventing and detecting healthcare fraud and abuse
- Tracking public health and risks
- Designing healthcare delivery systems
- Setting health policy
Transition Goals

• Reimbursement - would enhance accurate payment for services rendered

• Quality - would facilitate evaluation of medical processes and outcomes

• Flexibility – would incorporate emerging diagnoses and procedures

• Exactness – would identify diagnoses and procedures precisely
<table>
<thead>
<tr>
<th>ICD-9-CM diagnosis codes</th>
<th>ICD-10-CM diagnosis codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 characters in length</td>
<td>3-7 characters in length</td>
</tr>
<tr>
<td>First character is numeric or alpha (E or V)</td>
<td>First character is alpha (all letters except U )</td>
</tr>
<tr>
<td>Characters 2-5 are numeric</td>
<td>Character 2 is numeric Character 3-7 are alpha or numeric</td>
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<td>Use of decimal required after 3 characters</td>
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<tr>
<td>No placeholders</td>
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<td>Alpha characters are case sensitive</td>
<td>Alpha characters are NOT case sensitive</td>
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<tr>
<td>Incomplete code titles</td>
<td>Complete code titles</td>
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<tr>
<td>14,315 diagnosis codes (Volumes 1,2)</td>
<td>69,099 diagnosis codes (Volumes 1,2)</td>
</tr>
<tr>
<td>3,838 procedure codes (Volume 3)</td>
<td>71,957 procedure codes (Volume 3)</td>
</tr>
</tbody>
</table>

**ICD-9-CM ventricular fibrillation**

- **427**  
  - **category**

- **4**  
  - **Sub-category**

- **1**  
  - **Sub-Classification**
Fracture of angle of mandible subsequent encounter for closed fracture

Category
Sub Category
Additional Character
7th Character Extension
Etiology, anatomic site, severity
Obstetrics injuries external cause
Differences

• Laterality (left, right, bilateral)
  - C50.511 = Malignant neoplasm of lower- outer quadrant of right female breast
• Combination codes more specific
  - I25.110 = Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
• Two types of excludes notes

Differences

• Injuries grouped by anatomical site rather than by type of injury
• Category restructuring and code reorganization
  - 21 chapters instead of 17 chapters
• Placeholders ‘X’
• 7th characters
Implementation Date
October 1, 2014

OCTOBER 2014

ICD-10 Timeline for Small-Medium Practices at a Glance

<table>
<thead>
<tr>
<th>Planning</th>
<th>Jan</th>
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January 2013
Obviously we’ll need to make our own timeline.

Industry Readiness
Readiness Survey

What type of home health agency do you work for?

- Hospital affiliated
- Corporate owned, part of a large chain
- For profit, freestanding

Readiness Survey

If hospital affiliated, will home health ICD-10 training be included with hospital training?

- Yes
- No
Readiness Survey

Who will be responsible for your home health agency’s ICD-10 training?

- Agency employee(s)
- Paid consultant

Readiness Survey

Has your agency designated a transition team?

- Yes
- No
Readiness Survey

Has your agency performed a gap analysis?

- Yes
- No

0% 20% 40% 60% 80% 100%

Readiness Survey

Has your agency started training on the ICD-10-CM code set yet?

- Yes
- No

0% 20% 40% 60% 80% 100%
Readiness Survey

Do you think the ICD-10 compliance date will be delayed again?

Yes  20%

No  80%

Home Health Coders

- Solo Coder 44%
- 2 Person Team 25%
- 3+ person team 31%
Your Agency

- Who is responsible for the coding?
  - Field clinician
  - Centralized coder(s)
    - clinical
    - non clinical
      - 56% non clinical
      - 44% clinical
  - Outsource coding
- Does the coder also review the OASIS?

ICD-9 Productivity

- Coding responsibility ONLY:
  - 25 assessments per day
- Coding and OASIS review:
  - 15 assessments per day
- Internal quarterly audit results:
  - 90% > accuracy rating
Comparison

- Coder productivity first 12 months:
  - 70% longer to code claims
  - 54% decrease in productivity

  *Note: Data suggests initial productivity loss is never fully recovered*

- Coder productivity in the long term:
  - 20% decrease in productivity
  - Maintain a 90% > accuracy rating

Productivity Comparison

<table>
<thead>
<tr>
<th>ICD-9 Current</th>
<th>ICD-10 First 12 months</th>
<th>ICD-10 Long term</th>
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<tbody>
<tr>
<td>Coding:</td>
<td>Coding:</td>
<td>Coding:</td>
</tr>
<tr>
<td>25 assessments daily</td>
<td>11.5 assessments daily</td>
<td>20 assessments daily</td>
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<tr>
<td>Coding and OASIS Review:</td>
<td>Coding and OASIS Review:</td>
<td>Coding and OASIS Review:</td>
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<td>15 assessments daily</td>
<td>6.9 assessments daily</td>
<td>12 assessments daily</td>
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<td>Internal audit Review:</td>
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<tr>
<td>90% &gt; accuracy rating</td>
<td>90% &gt; accuracy rating</td>
<td>90% &gt; accuracy rating</td>
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</tbody>
</table>
Gap Analysis

• Assess employee knowledge gap
• Anatomy
• Physiology
• Pathophysiology
• Pharmacology
• Medical terminology

Anatomy
ICD-9 Example

• Patient admitted to home health with new diagnosis of CAD after acute MI 3 weeks ago. The focus of care is the CAD.

• M1020: 414.01 CAD
• M1022: 410.92 Acute MI
Anatomy Example

- Clinician documentation:
- ST elevation anterior wall
  - Left main coronary artery
  - Left anterior descending coronary artery
  - Other coronary artery of anterior wall
  - ST myocardial infarction of inferior wall
  - ST myocardial infarction of left circumflex coronary artery
- Length of time (4 weeks or less)
- History of tobacco use

Anatomy
ICD-10 Example

- Patient was treated for an right coronary MI in the last 3 weeks and is being admitted to home care for O and A of unstable angina and CAD. Patient was a long time smoker but quit 5 years ago.
Anatomy Example ICD-10

- M1021: I21.11 ST elevation (STEMI) myocardial infarction involving right coronary artery
- M1023: I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
- M1023: Z87.891 Personal history of nicotine dependence

Pharmacology Example ICD-9

- Patient admitted with diabetes mellitus with polyneuropathy due to long term steroid use and is taking insulin. Pt. also has rheumatoid arthritis.
- M1020: 249.60 secondary diabetes with neuro
- M1022: 357.2 polyneuropathy
- M1022: 714.0 rheumatoid arthritis
- M1022: V58.65 L/T use steroids
- M1022: V58.67 L/T use insulin
- M1022: E932.0 Adverse event to steroid use
Pharmacology Example
ICD-10

• Patient admitted with diabetes mellitus with polyneuropathy due to long term steroid use and is taking insulin. Pt. also has rheumatoid arthritis.
• M1021: E09.42 Drug induced diabetes with polyneuropathy
• M1023: T38.OX5D Adverse effect of glucocorticoids and synthetic analogues
• M1023: M06.09 Rheumatoid arthritis
• M1023: Z79.52 L/T use systemic steroids
• M1023: Z79.4 L/T use insulin

Pharmacology Example
ICD-10

• T38.OX5D Adverse effect of glucocorticoids and synthetic analogues
  
  Alpha listing:
  - Anabolic
  - Androgenic
  - Antineoplastic
  - Estrogen
  - ENT agent
  - Ophthalmic preparation
  - Topical NEC
Pharmacology Example
ICD-10

- Z79.52 L/T use systemic steroids
  Tabular listing:
  - Long term use of inhaled steroids
  - Long term use of systemic steroids

Pathophysiology Example
ICD-9

- Patient admitted for aftercare of hip fracture, sustained when patient fell out of bed. The fracture was repaired with an ORIF. Both nursing and therapy will see the patient.
  
  - M1020: V54.13 A/C hip fx  M1024: 820.8
  - M1022: E88.44 Fall from bed
Pathophysiology Example

ICD-10

• Patient admitted for aftercare of hip fracture, sustained when patient fell out of bed. The fracture was repaired with an ORIF.

• M1021: S72.042D Subsequent encounter for a closed displaced fracture of base of neck of left femur with routine healing

• M1023: W06.000D Fall from bed subsequent encounter

Pathophysiology Example

ICD-10

Appropriate 7th Character

D – Subsequent encounter for closed fracture with routine healing

E – Subsequent encounter for open fracture type I or II with routine healing

F – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing

G – Subsequent encounter for closed fracture with delayed healing
Pathophysiology Example

ICD-10

Appropriate 7th Character

H – Subsequent encounter for open fracture type I or II with delayed healing
J – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
K – Subsequent encounter for closed fracture with nonunion
M – Subsequent encounter for open fracture type I or type II with nonunion

N – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
P – Subsequent encounter for closed fracture with malunion
Q – Subsequent encounter for open fracture type I or II with malunion
R – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion
S – Sequela
Importance of Documentation

- CMS Requirements – CoPs
  - Homebound status
  - Medically reasonable and necessary
  - Intermittent skilled care
  - Coordination of care
- Reimbursement support
- Legal considerations
Importance of Documentation

• Then: If it’s not documented, it’s not done

• Now: If it’s not documented **thoroughly**, if it doesn’t support **reasonable** and **necessary**, if it is not **skilled**, the patient is not **homebound** and the agency may have provided multiple episodes and it’s **still** not done

Importance of Documentation

• CMS Program Safeguard Contractors
  - ZPICs
  - MACs
  - RACs
• Armed with information
• Their goals: Payment denials, recoupment of overpayments, and referral to other law enforcement agencies
Importance of Documentation

• CMS recently published “established recordkeeping principles” to provide further guidance regarding the timeliness of entries in medical records
• These principles apply to all Medicare contractors that review medical records

Impact of Error

• Compliance issue
• Payment issue
  - Upcoding
  - Downcoding
• Medical Review issue
  - lack of narrative
• Care Issue
• Survey Sanctions
ICD-10

• ICD-10 much more specific
• Robust documentation will be required
• - Home health clinicians
• - Referral sources
• - Hospitals
• - Physicians

ICD-10 transition team should include documentation specialists
• Identify every department whose workflow will be impacted: touch points
• Analyze impact on operational processes
• Assess the impact on documentation processes
• Perform a gap analysis on all clinicians
Documentation
ICD-10

- Assess employee knowledge gap
- Anatomy
- Physiology
- Pathophysiology
- Pharmacology
- Medical terminology

Physiology Example
ICD-10

- Patient admitted with diabetes mellitus with polyneuropathy due to long term steroid use and is taking insulin. Pt. also has rheumatoid arthritis.
- M1021: E09.42 Drug induced diabetes with polyneuropathy
- M1023: T38.OX5D Adverse effect of glucocorticoids and synthetic analogues
- M1023: M06.09 Rheumatoid arthritis
- M1023: Z79.52 L/T use systemic steroids
- M1023: Z79.4 L/T use insulin
<table>
<thead>
<tr>
<th>ICD-9 Rheumatoid Arthritis</th>
<th>ICD-10 Rheumatoid Arthritis</th>
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<td>Carditis</td>
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<td>Carditis</td>
<td>Endocarditis</td>
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**Stasis Ulcer**
**Stasis Ulcer**

**ICD-9 Example**

- Patient admitted for wound care to stasis ulcer of right calf due to postphlebitic syndrome.
- M1020: 459.13 Postphlebitic syndrome
- M1022: 707.12 non pressure calf ulcer

- In ICD-10 laterality is required and severity of wound

---

**Stasis Ulcer**

**ICD-10 Example**

- M1021: I87.011 Postthrombotic syndrome
- M1023: L97.212 Non pressure chronic ulcer of right calf with fat layer exposed
Stasis Ulcer
Documentation Requirements

• Clinician documentation:
  • Severity
    - Bone necrosis
    - Exposed fat layer
    - Muscle necrosis
    - Skin breakdown only
  • Laterality
    - Left
    - Right
    - Bilateral

Diabetes Mellitus
Diabetes Mellitus

• 5 categories of diabetes mellitus
  - Due to underlying condition
  - Due to chemical induced diabetes mellitus
  - Type 1 diabetes
  - Type 2 diabetes
  - Other specified diabetes

• Many are combination codes with specific manifestation information
• No character denotes controlled or uncontrolled

Diabetes Mellitus
ICD-9 Example

• Patient admitted for newly diagnosed type I diabetes with Chronic kidney disease. Patient on insulin.

• M1020: 250.41 Diabetes with renal
• M1022: 585.9 Chronic kidney disease
Diabetes Mellitus
ICD-10 Example

• Patient admitted for newly diagnosed type I diabetes with chronic kidney disease. Patient on insulin.
• M1021: E10.22 Type I diabetes mellitus with diabetic chronic kidney disease
• M1023: N18.9 Unspecified chronic kidney disease

• Note: Unspecified renal insufficiency is a choice but is not included the list of allowable pairings

Fractures
Trauma Fracture
ICD-9 Example

• Patient admitted for aftercare of hip fracture, sustained when patient fell out of bed. The fracture was repaired with an ORIF. Both nursing and therapy will see the patient.

• M1020: V54.13 A/C hip fx  
  M1024: 820.8
• M1022: E88.44 Fall from bed

Trauma Fracture
ICD-10 Example

• Patient admitted for aftercare of hip fracture, sustained when patient fell out of bed. The fracture was repaired with an ORIF.

• M1021: S72.042D Subsequent encounter for a closed displaced fracture of base of neck of left femur with routine healing
• M1023: W06.000D Fall from bed subsequent encounter
Example
ICD-10

Appropriate 7\textsuperscript{th} Character
D – Subsequent encounter for closed fracture with routine healing
E – Subsequent encounter for open fracture type I or II with routine healing
F – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
G – Subsequent encounter for closed fracture with delayed healing

Example
ICD-10

Appropriate 7\textsuperscript{th} Character
H – Subsequent encounter for open fracture type I or II with delayed healing
J – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
K – Subsequent encounter for closed fracture with nonunion
M – Subsequent encounter for open fracture type I or type II with nonunion
Example
ICD-10
Appropriate 7th Character
N – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
P – Subsequent encounter for closed fracture with malunion
Q – subsequent encounter for open fracture type I or II with malunion
R – Subsequent encounter for open fracture type type IIIA, IIIB, or IIIC with malunion
S – Sequela

S72.042D
• S72.0 – Fracture of head and neck of femur
• 7th character - encounter and type
• 4th 5th 6th character choices:
  • - Intracapsular
  • - Epiphysis
  • - Midcervical
  • - Base
  • - Articular
  • - Other
S72.042D

- Laterality
- Displaced
- Non-displaced
- Closed
- Open

S72.042D

- S72 = Fracture femur
- S72.0 = Fracture of head and neck of femur
- S72.04 = Fracture of base of neck of femur
- S72.042 = Fracture displaced
- S72.042D = Subsequent encounter for a closed fracture with routine healing
Preparation and Impact

Dual Coding

• Coding in ICD-9 and ICD-10
  – Keeping in mind that everything has to be in ICD-9 now
• Faster and more accurate
• Analyze what documentation is needed for better coding/better assessments.
  – Make changes to forms
  – Make list for intake personnel
Sample Dual Coding Plan

• Start by running a report on top 20 diagnoses your agency uses.
  – Kick out V57 codes.
  – Not just primary diagnoses.
  – Evaluate whether your list needs to include more than 20.

• Code the top 20 diagnoses in ICD-10-CM
  – Category enough?
  – What additional information do you need from your referral source and your clinicians to code these well?

Sample Dual Coding Plan

• Code one case per week in ICD-10-CM until December 31, 2013.
• Code three cases per week in ICD-10-CM January 1- March 31, 2014.
• Code five cases per week in ICD-10-CM April 1-August 2, 2014.
• Begin REAL dual coding August 3, 2014.
• Quality audits of all coders.
Episodes Spanning October 1\textsuperscript{st} SOC/ROC/Recerts

- CMS’ MLN Matters article released Feb. 24
- Revised twice
- M0090 (Date assessment completed) determines assignment of ICD-9 or ICD-10
- Removed language advising to use the GEMS to code claims that span Oct 1\textsuperscript{st}
- Corrected OASIS version for one example

---

Episodes Spanning October 1\textsuperscript{st} SOC/ROC/Recerts

- If \textit{both} the date of the RAP and the M0090 date are \textit{before} Oct.1
- ICD-9 codes should be used on the OASIS-C
- The HIPPS code will be generated with ICD-9 codes, even though the final claim will contain ICD-10 codes
Episodes Spanning October 1\textsuperscript{st} SOC/ROC/Recerts

• If the RAP date is \textit{before} Oct. 1, but the M0090 date is \textit{after} Oct. 1
• ICD-10 codes should be used on the OASIS-C1
• ICD-9 codes are reported on the RAP
• The HIPPS code will be generated with ICD-10 payment
• The ICD-9 codes reported on the RAP are only necessary for it to be processed

Episodes Spanning October 1\textsuperscript{st} SOC/ROC/Recerts

• If the M0090 date is \textit{before} Oct. 1 but the RAP date is \textit{after} Oct. 1 (patient is re-assessed before the first billable visit and within the 5-day window)
• ICD-9 codes should be used on the OASIS-C
• ICD-10 codes are reported on the RAP
• Though both the RAP and the final claim will contain ICD-10 codes, the payment-generating HIPPS code will be based on the ICD-9 codes reported on the OASIS.
Summary Table

<table>
<thead>
<tr>
<th>OASIS assessment Type</th>
<th>RAP “From Through” Dates</th>
<th>M0090 OASIS Version</th>
<th>Claim Through Date</th>
<th>Diagnosis Coding Used on OASIS</th>
<th>Diagnosis Coding Used on RAP</th>
<th>Diagnosis Coding Used on Claim</th>
</tr>
</thead>
</table>

Milestones
First Steps

• Identify who should be involved in the planning committee/task force
  – Do the preliminary work identifying people and processes and establishing and securing budget.

• Before real work can be done someone has to know what ICD-10 coding is and how it will impact processes.
Milestones
Next Steps

• Clinical Documentation Improvement for ALL KINDS of reasons
• Preliminary assessments of A&P, pathophysiology, pharmacology for clinicians, coders, QA
• When should coding training begin and for who?
  – Dual coding

Milestones
Next Steps

• Where is your software vendor in the ICD-10 process?
  – Don’t expect them to be through or almost through, but do expect them to know something about ICD-10
  – Have they done internal testing?
  – What tools did they build in or are building in to help with the transition?
  – Will they be beta testers for ICD-10, grouper, etc?
  – What will be the cost to YOU?
  – Who is involved in developing the assessment tools?
Gap Analysis

Definition: “...the comparison of actual performance with potential performance. Gap analysis provides a foundation for measuring investment of time, money and human resources required to achieve a particular outcome.”

Steps in a Gap Analysis

1. Analyze your current situation for each process and system by collecting information and data. (where we are now). Do this by looking at your agency introspectively and asking questions
   a. What are we currently doing?
   b. Who has the knowledge that you need?
   c. Is the information documented anywhere?
   d. What is the best way to obtain the information? Software reports? Interviews? Document review? Observation?
Steps in a Gap Analysis

2. Identify the objectives that must be achieved to achieve the overall goal. *(where we need to be)*

What are your goals now as to days to RAP?

How long does it take to get assessments complete? How many assessments are acceptable when first submitted and how many times does the coder have to go back to the clinician for additional information?

What are achievable objectives for each issue identified?

You have to know where you are to know what to do to get where you are going...
Steps in a Gap Analysis

3. Identify how to bridge the gap from the current situation to the desired outcome (*how do we get there*). Consider what resources you will need to take to reach the objective, and then take action!
   a. People
   b. Processes
   c. Technology
   d. Time
   e. Materials and Equipment

Areas to be addressed in Gap Analysis

Financial
   - Billing/Revenue cycle
   - Cash Flow
   - Budget
   - HHRG changes

Operational
   - Intake/referral
   - IT/Outside Vendors

Clinical
   - Clinical documentation
   - OASIS C-1 completion
   - Case Management

Coding
   - competency ICD-9 and ICD-10
What are some of the issues now?

- Little to no clinical information available at referral/intake.
  - More difficult to identify patient issues
  - More difficult to develop POC meaningful to the patient
  - More difficult to provide skilled care that will withstand the scrutiny
- How do we get better information to begin with AND
- How do we get the clinicians to assess/document better?

CMS Guidance
Preparation

• 5 areas of training were considered by CMS
• Methodology
• Clinical specialty
• Number of coders
• Number of hours for coder training
• Cost per hour of training

Preparation

• CMS and AHIMA recommend training time line to be no sooner than 9 months prior to implementation (October 1, 2014)
• If training occurs sooner, the agency would need to retrain

• Note: This time line is not referencing the agency ICD-10 trainer(s)
Preparation

- Implementation ICD-10-CM:
  - Coders = 16 hours training
  - Gap knowledge deficit = 8 hours additional
  - Total = 24 hours training time
  - CMS estimate $644 per coder

  - Note: This time frame and cost is for full time coders only – not other agency personnel who need an overall understanding (i.e. senior management, accounting, quality improvement staff)

Coding Specialist Training

- 9 months prior to implementation date
- Canada’s experience for coding specialist training
  - 50 hours training plus 8 hours knowledge gap training
  - Total of 58 hours training
- Coding audits
- elearning
- Practice tools
- Webinars
- Discussion forums
- Classroom education
- Live events
Clinician Training

- 6 months prior to implementation date
- Canada’s experience for clinical training
  - 30 hours training plus 8 hours knowledge gap training
  - Total of 38 hours training
- Initial assessments/audits
- elearning
- Practice tools
- Webinars
- Discussion forums
- Classroom education
- Live events

Documentation Training

- Clinical Documentation training:
  - ICD-10 transition overview
  - Agency impact overview
  - Conventions and guidelines
  - Anatomy and physiology
  - OASIS/HHRG
  - Compliance
  - Intermediate ICD-10 diagnosis specific
  - If clinician is the coder:
  - Advanced ICD-10 diagnosis specific
Preparation

• Required software changes will affect coding processes
• Testing with vendor and intermediary before the ‘go live’ date is a must
• Duel coding will be required for a period of time
• Lower payment structure for unspecified codes may result

Impact

• New code set will produce a temporary increase in coding errors resulting in rejected claims
• Medicare expects a spike in rejected claims 3 to 6 months following introduction of code set, peaking at 10% of all claims submitted
• Productivity will be directly affected because of the need to learn new codes and definitions
Impact

• Coding clinic guidance will be retired so ‘unlearning’ rules will be as important as learning the new code set
• In 2015, CMS estimates a 9.77 million dollar loss in coder productivity (based on each assessment requiring an additional 1.7 minutes to complete)
• CMS expects the Home Health industry to have an overall transition cost from ICD-9 to ICD-10 of 16.58 million dollars

Impact

• Increased delay in processing claims
• Increased claim rejections and denials
• Improper claims payment
• Coding backlog
• Compliance anomalies
• Decreased cash flow
### Sample Timeline for Home Health

<table>
<thead>
<tr>
<th>2013</th>
<th>2014</th>
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</thead>
<tbody>
<tr>
<td>October</td>
<td>Nov</td>
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<tr>
<td>Nov</td>
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<td>Jan</td>
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<td>November</td>
<td>Nov</td>
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<tr>
<td>Dec</td>
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</tr>
</tbody>
</table>

**PLANNING**
- Identify resources
- Create project team
- Assess effects
- Create project plan
- Secure budget

**COMMUNICATIONS**
- Inform staff
- Contact vendors
- Contact payers
- Monitor vendor prep

**TESTING**
- High-level testing
- For full team

**COMPREHENSIVE TRAINING**
- Documentation
- Coding
- ICD Coding Practice
- Discharge Form

**Ongoing**
- Ongoing vendor audits
- Ongoing payer audits
- Ongoing quality audits
- Ongoing compliance audits
- Ongoing education activities
Sample Timeline for Home Health

2013 2014

Oct Nov Dec Jan Feb March April May June July August Sept Oct Nov Dec

TESTING
High-level training for test team
Level 1: Internal
Level 2: external COMPREHENSIVE TRAINING
Contact your software vendor and NGS for possibilities
Documentation Coding
Dual Coding Practice Dual Coding Actually Begins

2013 2014

Oct Nov Dec Jan Feb March April May June July August Sept Oct Nov Dec

OTHER ANALYSES/TASKS
Review list of proposed cmdx
Additional training on grouper
Training on OASIS C-1
Evaluate grouper for impact
on payment
Ongoing quality audits

107 | Title of Presentation  107

108 | Title of Presentation  108
Impact

- Do I have the right employees on the coding team?
- Do they need remedial education prior to ICD-10 training?
- Should I hire additional coders?
- Should I consider a short term agreement with an outsource coding company?
- Should I outsource all coding?

Take Away Points

- Review medical record documentation on most frequently coded conditions
- Focus on charts that lead to the highest or most common denial rates
- Identify documentation improvement opportunities
- Comprehensive education and mentoring
- Develop coder and clinician interactions
Take Away Points

- Partner with the right education sources
- High quality documentation will increase the benefits of the new coding system
- High quality documentation is increasingly being demanded by other initiatives
- High quality documentation and accurate coding are on the door step of home health in an ICD-10 environment

Take Away Points

- Preparation is the key
- Communication is vital
- Establish a team to implement the transition
- Payment in part, will be linked to precise coding
- Accurate coding depends on thorough documentation
- Both are critical to your organizational success in an ICD-10 environment
What questions do you have?

Tricia A. Twombly BSN RN HCS-D HCS-O COS-C CHCE
AHIMA Approved ICD-10 CM Trainer
AHIMA Ambassador

Senior Director
DecisionHealth

Chief Executive Officer
Board of Medical Specialty Coding and Compliance

www.decisionhealth.com
ttwombly@decisionhealth.com