ICD-10 Comes Early To Home Health

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First Things First
Implementation Date:
Oct. 1, 2015

ICD-9-CM
History
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- Outdated medical terms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

<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>
</tr>
<tr>
<td>Lacks laterality</td>
<td>Has laterality</td>
</tr>
<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>
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
Suggested Timeline Phases

Timeline

Planning Phase
October 2014 through January 2015

- Identify resources
- Create project team and inform staff
- Assess impact on organization
- Secure budget
Timeline

Development Phase
October 2014 through January 2015
✓ Develop documentation improvement plan
✓ Develop project plan
✓ Develop education plan
✓ Contact partners

Timeline

Testing and Training Phase
October 2014 to October 2015
✓ High level training for project team
✓ Comprehensive training
  - clinicians
  - coding specialists
  - other essential personnel
Comprehensive Training

✓ Documentation: March 2015 to October 2015

   Dual Coding: (per coding specialist)
   ✓ 3% records per week: January 2015
   ✓ 5% records per week: February 2015
   ✓ 15% records per week: March and April 2015
   ✓ 25% records per week: May and June 2015
   ✓ 50% records per week: July 2015
   ✓ 100% records per week: August 3rd 2015 →

Timeline

Preparation and Impact Phase
January 2015 and forward

✓ Go-live preparation
✓ Monitor, measure and manage completed steps
Transition Steps

Step 1 – Identify Resources
Step 2 – Create Project Team/Inform Staff
Step 3 – Assess Impact on Your Agency
Step 4 – Secure Budget
Step 5 – Identify Challenges & Develop Project Plan
Step 6 – Contact Vendors, Payers & Monitor Prep
Step 7 – High Level Training for Test Team
Step 8 – Comprehensive Training
Step 9 – Final Preparation
Step 10 – Monitor, Measure and Manage

Step 8
Comprehensive Training
Training

• 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

Training

• CMS and AHIMA recommend training time line to be no sooner than 9 months prior to implementation (October 1, 2015)
• If training occurs sooner, the agency would need to retrain

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

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

- Note: This estimated 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)

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Training

- Canada’s implementation experience:
  - Coders = 50 hours training
  - Gap knowledge deficit = 15 additional hours
  - Total = 65 hours training time

- Note: Participating U.S. test hospitals had a 20% decrease in case mix: 90% of the decrease were coding errors, not the result of revised Grouper case mix
**Your Organization**

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

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

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.”
Pathology Example

ICD-9

• Patient admitted with decompensating CHF. Patient also has HTN, CAD, and requires oxygen.
• M1020: 428.0 CHF
• M1022: 401.9 HTN
• M1022: 414.01 CAD
• M1022: V46.2 Supplemental O2

Note: In ICD-10, the pathology of the heart failure should be documented and coded.

ICD-10

• Patient admitted with decompensating CHF. Patient also has HTN, CAD, and requires oxygen.
• M1021: I50.9 Unspecified heart failure
• M1023: I10 HTN
• M1023: I25.10 CAD
• M1023: Z99.81 Supplemental O2

Note: In ICD-10, the pathology of the heart failure should be documented and coded.
Anatomy 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
  • M1022: E88.44 Fall from bed
  • M1024: 820.8

Anatomy 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
Anatomy 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

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
Anatomy 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

Pathophysiology Example
ICD-9
• Patient admitted for newly diagnosed type I
  diabetes with chronic kidney disease. Patient
  on insulin.

• M1020: 250.41 Diabetes with renal
• M1022: 585.9 Unspecified chronic kidney
disease
Pathophysiology Example
ICD-10

- Patient admitted for newly diagnosed type I diabetes with chronic kidney disease. Patient on insulin.
- M1020: E10.22 Type I diabetes mellitus with diabetic chronic kidney disease
- M1022: N18.9 chronic kidney disease

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

Importance of Intake Team
## Sample Intake Information

<table>
<thead>
<tr>
<th>Current Responsibilities</th>
<th>Responsibilities in I10</th>
<th>Sample process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake personnel take information from referral source and directed to ask certain questions if information is not offered, such as demographic info, next of kin, who will sign F2F, etc</td>
<td>Intake personnel will obtain better clinical information so that assessments, documentation and coding can be more accurate and complete.</td>
<td>Should have some education in coding to ensure that clinical information is as complete as possible at intake stage. Provided questions based on common diagnoses for referral source.</td>
</tr>
</tbody>
</table>

## Sample Intake Tool

<table>
<thead>
<tr>
<th>Diagnosis/Condition</th>
<th>Sample Query Questions</th>
<th>Documentation</th>
</tr>
</thead>
</table>
| Fractures           | Could you provide the radiology report that includes the location and type of fracture? | PCP H&P report
                                    |                          | Surgical report         |
|                     |                         | Radiology report    |
|                     |                         | Discharge summary    |
| Heart failure       | Does the CHF have a diastolic or systolic component? | Cardiologist report |
|                     |                         | PCP H&P report       |
|                     |                         | Cath/other procedures report |
|                     |                         | Discharge summary    |
| Osteomyelitis       | Is the osteo from a soft tissue injury or blood infection? | PCP H&P report |
|                     |                         | Radiology report     |
|                     |                         | Discharge summary    |
|                     |                         | Surgical report      |
Step 9
Final Preparation

Revenue Cycle Weaknesses

• How long are claims sitting in accounts receivable before being submitted to the payer?
• What percentage of your potential claims revenue is being written off due to timely filing deadlines?
• How long is your billing department taking to submit Medicare RAPs and claims?
Revenue Preparation

CMS and other industry leaders are recommending that agencies have available enough credit/cash to keep operating for 6 months with no revenue coming in.

This suggestion anticipates a “big bang” Y2K scenario, which we hope will not happen, but as always—better safe than sorry.
Revenue Preparation

- Expand existing line of credit
- Contact a bank/lender who understands the specialized financing requirements of healthcare practitioners
- Contact your Small Business Administration (SBA) office
- Know that banks are unlikely to approve new lines of credit for managing cash flow

Prospective Payment System

- All Medicare providers are paid on a prospective payment system based on a case mix score
- Hospitals are paid via discharge diagnoses and procedures = DRG
- Home Health is paid via certain OASIS responses in 3 different areas = HHRG
PPS Reimbursement

- Based on the OASIS data, the Grouper assigns a HIPPS code to the patient.
- The characters in the HIPPS code are:
  - 1\textsuperscript{st} character = # of visits/early or late episode
  - 2\textsuperscript{nd} character = clinical severity (diagnoses)
  - 3\textsuperscript{rd} character = Functional Severity (ADL/IADL)
  - 4\textsuperscript{th} character = Service Utilization (therapy)
  - 5\textsuperscript{th} character = Non- routine supplies (NRS)

PPS Reimbursement

 HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

\[ \text{Base rate} \times \text{HHRG} = \text{Case-mix Adjusted Rate} \]

\[ \text{Labor and Non-labor Adjustment} + \text{NRS Payment} \]

\[ \text{Geographic Factors} \]

\[ \text{Payment} \]
60 Day Episode

- To ensure adequate cash flow a split percentage payment is utilized
- Initial episode = 60/40 % split
  - 60% paid at beginning of episode
  - 40% paid at end of episode
- Subsequent episodes = 50/50 % split
  - 50% paid at beginning of episode
  - 50% will be paid at end of episode

60 Day Episode

- HHA’s bill a request for anticipated payment (RAP) at the beginning of the episode
- HHA’s bill the end of episode payment (EOE) no sooner than the 60th day of the episode
- HHA’s will have episodic billing cycles spanning the ICD-10 implementation date
Now It Gets Really Confusing

Episodes Spanning October 1st
SOC/ROC/Recerts

• CMS’ MLN Matters article released Feb. 24, 2014
• M0090 (Date assessment completed) determines assignment of ICD-9 or ICD-10
• It’s important to note that the M0090 date is a different date than the start of episode date
Episodes Spanning October 1st
SOC/ROC/Recerts

• If both the date of the RAP and the M0090 date are before Oct.1
• ICD-9 codes should be used on the OASIS-C1-I9
• The HIPPS code will be generated with ICD-9 codes, even though the final claim will contain ICD-10 codes

Episodes Spanning October 1st
SOC/ROC/Recerts

• If the RAP date is before Oct. 1, but the M0090 date is after Oct. 1
• ICD-10 codes should be used on the OASIS-C1-I10
• 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 1st
SOC/ROC/Recerts

- If the M0090 date is before Oct. 1 but the RAP date is 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-C1-I9
- 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 Date OASIS Version</th>
<th>EOE Claim Through Date</th>
<th>Diagnosis Coding Used on OASIS</th>
<th>Diagnosis Coding Used on RAP</th>
<th>Diagnosis Coding Used on Claim (EOE)</th>
</tr>
</thead>
</table>
The REAL Beginning

PPS Reimbursement

- Home health must begin dual coding 100% of claims starting August 3, 2015
- Rap will be billed with ICD-9 codes
- EOE will be billed with ICD-10 codes
- Reimbursement could be with ICD-9 or ICD-10 codes depending on the date the assessment was completed
Readiness Checklist

• PLAN
• PREPARE
• PERFORM

Identify Resources
Step 1

• Conduct information systems inventory
• Assess vendor readiness and support
• Identify necessary conversion tools
• Identify areas requiring operational and policy changes
• Identify stakeholders (i.e. referral sources, vendors, clearing houses, payers etc)
Create Project/Implementation Team
Step 2

• Inform all employees
• Conduct staff responsibility analysis
• Assess staff for their level of readiness

Assess Impact on Organization
Step 3

• Review list of most used common ICD-9-CM codes
• Conduct GAP analysis of general staff and systems
• Conduct GAP analysis of billing, clinician and coding specialists
• Assess documentation practices
• Analyze the Grouper for impact on payment

3/23/2015
Secure Budget
Step 4

• Identify resource and system needs
• Determine stakeholder education and training needs
• Identify software upgrades/system changes
• Estimate productivity loss (i.e. billing, coding)
• Reassess and revisit budget throughout the implementation period

Identify Challenges/Develop Plan
Step 5

• Identify and create a communication plan
• Develop coding specialist education plan
• Develop clinician documentation improvement plan
• Develop referral source documentation improvement plan
• Develop referral source documentation improvement plan
Contact Partners
Step 6

• Identify, contact and ensure involvement and commitment of:
  • Vendors
  • Payers
  • Physicians
  • Clearinghouses
  • Internal staff
  • Others specific to your agency

High Level Training for Project Team
Step 7

• Conduct general staff training
• Test/validate system changes
• Monitor work flow volumes to minimize backlogs
• Select and train champion coding specialist (ICD-10-CM)
• Select and train champion documentation specialist (OASIS-C1)
Comprehensive Training
Step 8
• OASIS C1-10 staff training
• Clinician ICD-10 training; intermediate level
• Coding specialist ICD-10 training; advanced level
• Other essential personnel training at intermediate or advanced level (i.e. QA, QI, billing etc.)

Go-live Final Preparation
Step 9
• Finalize and test system changes
• Conduct acknowledgment testing with payers/software vendor/clearinghouses/MAC
• Conduct end to end testing with payers/software/vendor/clearinghouses/MAC
• Assess/adjust case mix impact
• Audit coding accuracy
• Assess and adjust for ICD-10 Grouper reimbursement impact
Monitor, Measure and Manage
Step 10

- Manage target dates for each action item and monitor compliance
- Measure coding productivity
- Monitor documentation improvements
- Monitor referral source documentation improvement
- Manage continued coding and documentation education
- Measure competencies to evaluate knowledge and skills
- Manage on-going quality audits

Impact

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

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 2016, 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
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?
Presenter Information

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