The ICD-10 Workshop: What do I need to know to survive 10-01-2014?

58th Annual Greenville Postgraduate Seminar: A Primary Care Update

Nick Ulmer, MD CPC
Vice President, Clinical Services and Medical Director, Case Management Spartanburg Regional Healthcare System Spartanburg, South Carolina
The ICD-10 Workshop: What is left After Congress and President Obama Wiped My Talk Away

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Nick Ulmer, MD CPC
Vice President, Clinical Services and Medical Director, Case Management
Spartanburg Regional Healthcare System
Spartanburg, South Carolina
Objectives

- I have no objectives because of Congress
- I have no objectives because of Obama
  - Signed into law 04-01-2014 (April Fool’s)
- I have no objectives because I redid the talk over the last 4 days..........

😊
Objectives

- Explain what happened early last week and how the landscape looks for ICD-10
- Define the history of the ICD and understand the “why” behind the pathway to ICD-10
- Provide a brief overview of ICD-10 to allay fears and realize where the concerns really lie
- Talk about how clinically correct coding will play in our future as it relates to ICD-9 and ICD-10
- Realize strategies for success in the outpatient and inpatient clinical settings for optimal roll-out of ICD-10
First.........update

- Congressional action
  - End of March the **House** passed the “SGR Fix” bill: *Protecting Access to Medicare Act of 2014*
    - Halted a 24% pay cut to physicians via the SGR
    - Had a stipulation to delay the 2 MN rule
    - Pushed back the ICD-10 rollout to 10-2015
      - ICD concerns: “end to end testing” by CMS
  - **Senate** action Monday 03-31-2014
    - Temporary fix to the SGR (freeze rates for 1 year, continue 0.5% raise)
    - “cannot adopt ICD-10 before 10-2015”....
    - 6 more months delay in enforcing 2 MN rule
  - President signed next day
Review of the “2 MN Rule”

- Physician Certification
  - “Admit to IP” clearly written
  - Diagnosis
  - Reason for IP care in hospital
  - LOS expected (“2 MN”)
  - Discharge plans
  - Sign before discharge from hospital
My concern.....

- CMS is quiet.....and that worries me
- Healthcare providers (hospitals and groups) are set for 10-2014
  - Too early to roll-out...and other systems won’t be on the same timeline
  - Wasted time and $$
  - Vendor EMR roll-outs are already under contract...now what.....?
- Big projects get canned all of the time...but put on hold.....for an indefinite period of time....?
So......

- After being told this was to go live 10-2013, it did not
- Now, after being told repeatedly “no more delays”...... we see it again delayed.
- The Healthcare Family feels burdened...
Terminology

- **HIPAA** – Health Insurance Portability and Accountability Act of 1996
- **ICD-9-CM** – International Classification of Diseases, 9th Revision, Clinical Modification
- **ICD-10-CM** – International Classification of Diseases, 10th Revision, Clinical Modification – diagnosis code set
- **ICD-10-PCS** – International Classification of Diseases, 10th Revision, Procedure Coding System – procedure code set
- **CPT** – Current Procedural Terminology
- **HCPCS** – Healthcare Common Procedure Coding System
- **WHO** – World Health Organization
- **NCHS** – National Center for Health Statistics, Center for Disease Control and Prevention
- **CMS** – Centers for Medicare & Medicaid Services
History Of International Classification of Diseases (ICD)

1620-1674
History of ICD-10: “ICD-1”

- Bertillon Classification of Causes of Death
  - Created by Jacques Bertillon, MD (1851-1922), Chief of Statistical Services of the City of Paris
  - an abridged classification of 44 titles
  - Realized a correlation between suicide rates and divorces
    - Felt both were associated with “social disequilibrium”
- The International List of Causes of Death (1893)…the first
- Followed by…ICD-2, ICD-3, ICD-4, ICD-5, ICD-6, ICD-7, ICD-8, ICD-9…. 
History Of International Classification of Diseases (ICD)

- The International Statistical Institute managed ICD until ICD-6 (1948)
- The World Health Organization took over ICD 1948
  - 10 international centers helped modify ICD
  - Use as tool so that medical terms reported by Physicians, Medical Examiners, and Coroners on death certificates can be grouped together for statistical purposes
International Classification of Diseases (ICD)

- Since 1900, the ICD has been modified about once every 10 years, except for the 20-year interval between the last two revisions, ICD-9 and ICD-10.

<table>
<thead>
<tr>
<th>Designation</th>
<th>Years in Effect</th>
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<tbody>
<tr>
<td>ICD-1</td>
<td>1900-1909</td>
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<tr>
<td>ICD-2</td>
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<td>1921-1929</td>
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<td>1939-1948</td>
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<td>1949-1957</td>
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<td>ICD-7</td>
<td>1958-1967</td>
</tr>
<tr>
<td>ICDA-8 (adapted*)</td>
<td>1968-1978</td>
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<tr>
<td>ICD-9</td>
<td>1979-1998</td>
</tr>
<tr>
<td>ICD-10</td>
<td>1999-</td>
</tr>
</tbody>
</table>
Other Countries are ahead of US

<table>
<thead>
<tr>
<th>Country</th>
<th>Year Implemented ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td>1995</td>
</tr>
<tr>
<td>France</td>
<td>1997</td>
</tr>
<tr>
<td>Australia</td>
<td>1998</td>
</tr>
<tr>
<td>Belgium</td>
<td>1999</td>
</tr>
<tr>
<td>Germany</td>
<td>2000</td>
</tr>
<tr>
<td>Canada</td>
<td>2001</td>
</tr>
<tr>
<td>United States</td>
<td>2013...2014...2015</td>
</tr>
</tbody>
</table>
No longer morbidity and mortality

- The international standard classification for
  - General epidemiological info
  - Health management purposes
- Clinical uses
  - Population health management
  - Disease prevalence
  - Quality metrics
  - Reimbursement/resource allocation
- Documentation of the encounter is how we translate the clinical picture into code sets
  - Translation is difficult with ICD-9 at times
What is ICD-9-CM Used For?

- Calculate payment – Medicare Severity-Diagnosis Related Groups (MS-DRGs)
What is ICD-9-CM Used For?

- Calculate payment – Medicare Severity-Diagnosis Related Groups (MS-DRGs)
- Adjudicate coverage – diagnosis codes for all settings
- Compile statistics
- Assess quality
ICD-9-CM Basics

- ICD-9-CM has 3 – 5 digits
- Chapters 1 – 17: all characters are numeric
- Supplemental chapters: first digit is alpha (E or V), remainder are numeric

Examples:
- 496 Chronic airway obstruction not elsewhere classified (NEC)
- 511.9 Unspecified pleural effusion
- V02.61 Hepatitis B carrier
ICD-9...Do You Know?

- Code for benign essential hypertension?
- Code for unspecified essential hypertension?
- ...for malignant essential hypertension?
  - ...from a pheochromocytoma?
- What about CHF?
- ...benign hypertensive heart disease w CHF?
- What about chest pain?
- ...chest wall pain?
- ...chest pain with breathing?
ICD-9...Do You Know?

- Code for benign essential hypertension? 401.1
- Code for unspecified essential hypertension? 401.9
- ...for malignant essential hypertension? 401.0
  - ...from a pheochromocytoma? 405.99
- What about CHF? 428.0
- ...benign hypertensive heart disease w CHF? 402.11
- What about chest pain? 786.50
- ...chest wall pain? 786.51
- ...chest pain with breathing? 786.52

- How did you do....?
ICD-9-CM is Outdated

- 30+ years old – technology has changed
- Many categories full
- Not descriptive enough
  - Research limitations
  - Payment limitations
- Unable to compare across countries
ICD-9 and ICD-10 Differences

- ICD-10 CM codes are alpha-numeric, as opposed to primarily numeric in ICD-9
  - Malignant neoplasm, upper third esophagus C15.3
  - Malignant neoplasm, upper third esophagus 150.3
  - Essential (primary) hypertension I10.
  - Unspecified essential hypertension 401.9
  - Acute tonsillitis J03
  - Acute tonsillitis 463
ICD-9 and ICD-10 Differences

- ICD-10 CM codes are alpha-numeric, as opposed to primarily numeric in ICD-9.
- ICD-10 CM codes contain up to a maximum of 7 characters, as opposed to the 5 characters seen in ICD-9.
- Late effects are handled differently.
  - Late effects (ICD-9) are referred to as *sequela* (ICD-10) and these events are noted with the addition of an additional digit to address the condition that caused the sequela.
ICD-9 and ICD-10 Differences

- ICD-9 has 17 chapters, ICD-10 has 21
  - ICD-10 has separate chapters for eye/adnexa and ear/mastoid
  - There is an ICD-10 chapter 22, but it is not used for international data comparison and therefore this chapter is not included in the ICD-10 CM for the US
- The “External Cause” codes (V and E codes) for ICD-9 are not “supplemental” in ICD-10 as they have their own chapters (20,21)
- ICD-10 codes are organized differently than in ICD-9
  - Sense organs have been separated from nervous system disorders
  - Post-operative complications have been moved to procedure-specific body system chapter
  - Injuries are grouped by anatomical site, not by injury category
Injury Changes

- **ICD-9-CM**
  - Fractures (800-829)
  - Dislocations (830-839)
  - Sprains and strains (840-848)

- **ICD-10-CM**
  - Injuries to the head (S00-S09)
  - Injuries to the neck (S10-S19)
  - Injuries to the thorax (S20-S29)
## ICD-9 and ICD-10 Differences

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Example:

- fracture of wrist:
  - Patient fractures left wrist
  - A month later, fractures right wrist
  - ICD-9-CM does not identify left versus right – requires additional documentation

- ICD-10-CM describes Left versus right
- Initial encounter, subsequent encounter
- Routine healing, delayed healing, nonunion, or malunion
ICD-10-CM Diagnosis Codes

- Characters 1-3 – Category

- Example:
  - **S52** Fracture of forearm
ICD-10-CM Diagnosis Codes

- Characters 1-3 – Category
- Characters 4-6 – Etiology, anatomic site, severity, or other clinical detail

**Example:**
- **S52** Fracture of forearm
ICD-10-CM Diagnosis Codes

- Characters 1-3 – Category
- Characters 4-6 – Etiology, anatomic site, severity, or other clinical detail

Example:
- **S52** Fracture of forearm
- **S52.5** Fracture of lower end of radius
- **S52.52** Torus fracture of lower end of radius
- **S52.521** Torus fracture of lower end of right radius
ICD-10-CM Diagnosis Codes

- Characters 1-3 – Category
- Characters 4-6 – Etiology, anatomic site, severity, or other clinical detail
- Characters 7 – Extension (initial visit, subsequent, etc.)

Example:
- S52 Fracture of forearm
- S52.5 Fracture of lower end of radius
- S52.52 Torus fracture of lower end of radius
- S52.521 Torus fracture of lower end of right radius
ICD-10-CM Diagnosis Codes

- Characters 1-3 – Category
- Characters 4-6 – Etiology, anatomic site, severity, or other clinical detail
- Characters 7 – Extension (initial visit, subsequent, etc.)

**Example:**
- **S52** Fracture of forearm
- **S52.5** Fracture of lower end of radius
- **S52.52** Torus fracture of lower end of radius
- **S52.521** Torus fracture of lower end of right radius
- **S52.521A** Torus fracture of lower end of right radius, initial encounter for closed fracture
The 7\textsuperscript{th} Character

- 7th character used in certain chapters (e.g., Obstetrics, Injury, Musculoskeletal, and External Cause chapters)
- Different meaning depending on section where it is being used
- Must always be used in the 7th character position
- When 7th character applies, codes missing 7th character are invalid
**7th Character Defined**

- **Initial encounter:** As long as patient is receiving active treatment for the condition.
  - Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

- **Subsequent encounter:** After patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
  - Examples of subsequent care are: cast change or removal, removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition.

- **Sequela:** Complications or conditions that arise as a direct result of a condition (e.g., scar formation after a burn).

*Note:* For aftercare of injury, assign acute injury code with 7th character for subsequent encounter.
7th character in fractures

- **A**  Initial encounter for closed fracture
- **B**  Initial encounter for open fracture
- **D**  Subsequent encounter for fracture with routine healing
- **G**  Subsequent encounter for fracture with delayed healing
- **K**  Subsequent encounter for fracture with nonunion
- **P**  Subsequent encounter for fracture with malunion
- **S**  Sequela
General Equivalency Mapping

- Maps should not be used to assign codes to report on claims
- GEMs and Reimbursement Mappings are not a substitute for learning how to use ICD-10-CM/PCS
- Mapping ≠ coding
  - Mapping links concepts in 2 code sets without consideration of context or medical record documentation
  - Coding involves assignment of most appropriate codes based on medical record documentation and applicable coding rules/guidelines – GEM is not a substitute for correct coding
- GEM:  [www.cdc.gov/nchs/icd/icd10cm.htm](http://www.cdc.gov/nchs/icd/icd10cm.htm)
- My favorite: [ICD10data.com](http://ICD10data.com)
GEM may not be answer

- Healthcare intelligence software
  - Data mines claims and produces DRG options and looks at ICD-9 → ICD-10 permutations and transitions
    - Groups together to get best DRG option possible
    - Some ICD-9 codes will translate into multiple ICD-10
    - Some ICD-9 codes will not be found in ICD-10
    - Some ICD-9 will be found in combination codes
Physician impact

- More queries as Clinical Documentation Improvement staff will catch fall-out.
- More frustration with trying to enter codes in the outpatient world of office settings
- Staff frustration with new codes, increased denials
  - Trickle down effect
  - Financial downward pressure (vicious cycle)
Will patients be impacted?

- Quality reporting to this degree of specificity is good for medicine
- Financially, no (unless office issues cause billing problems noted prior)
- Clinically speaking, no (unless flow is impacted at the office level due to difficulties in correct coding)
Cost estimates
ICD-10 implementation

- Areas of cost concern
  1. Education of physicians and staff
  2. Process analysis for needed flow change
  3. Modification of code sets to paper tracking/superbills
  4. IT upgrades
    - 29 different applications at SRHS that must be enhanced
  5. Increased documentation issues
  6. Cash flow slow-down due to slowness of system to pay and appeals/denials
Since Washington Ruined My Talk…What About I-9 Coding Opportunities?

- Need to pay attention to the detail of documentation
  - Translates into dollars now for Hospitals
  - ...............into dollars later for physicians
The record reflects severity, intensity and medical necessity through the documentation of diagnoses and procedures.

CPT codes are not used.
The record reflects severity, intensity and medical necessity through the documentation of diagnoses and procedures.

CPT codes are not used.
### MS-DRG Structure-Medical

- **Simple Pneumonia**
  - DRG 195  w/o CC/MCC: $4,541
  - DRG 194  with CC: $6,414  **Difference $1,873**
  - DRG 193  with MCC: $9,556  **Difference $3,142**
MS-DRG Structure-Medical

- **Simple Pneumonia**
  - DRG 195 w/o CC/MCC $4,541
  - DRG 194 with CC $6,414  Difference $1,873
  - DRG 193 with MCC $9,556  Difference $3,142

- **Complex Pneumonia**
  - DRG 179 w/o CC/MCC $6,287  Difference $1,746
  - DRG 178 with CC $9,242  Difference $2,955  Difference $2,828
  - DRG 177 with MCC $13,185  Difference $3,943  Difference $3,629
## MS-DRG Structure-Medical

<table>
<thead>
<tr>
<th>Condition</th>
<th>DRG 195  w/o CC/MCC</th>
<th>DRG 194  with CC</th>
<th>DRG 193  with MCC</th>
<th>Difference</th>
</tr>
</thead>
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<td>$6,287</td>
<td>$9,242</td>
<td>$13,185</td>
<td>$1,746</td>
</tr>
<tr>
<td>CHF</td>
<td>$4,332</td>
<td>$6,438</td>
<td>$9,736</td>
<td>$2,106</td>
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Severity of Illness (SOI) defined

The extent of physiologic decomposition, organ system loss of function, and/or mortality.

Refers to:
- How sick is the patient?
- How difficult is the patient to manage?
- What types of interventions are required?
- What is the intensity of resources utilized?
# Documentation Guidelines: Heart Failure

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>High Severity</th>
<th>Moderate Severity</th>
<th>Low Severity</th>
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</thead>
<tbody>
<tr>
<td>Congestive heart failure “CHF”</td>
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<td></td>
<td>X</td>
</tr>
<tr>
<td>Rheumatic heart failure</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Left heart failure</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Unspecified systolic and/or diastolic heart failure</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Chronic systolic and/or diastolic heart failure</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Acute systolic and/or diastolic heart failure</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Acute on chronic systolic and/or diastolic heart failure</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
How are Severity and Risk of Mortality Measured?
How are Severity and Risk of Mortality Measured?

By documenting secondary diagnoses!

<table>
<thead>
<tr>
<th>Severity of Illness</th>
<th>Secondary Diagnosis-Diabetes Mellitus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minor Uncomplicated Diabetes</td>
</tr>
<tr>
<td>2</td>
<td>Moderate Diabetes w Renal Manifestation</td>
</tr>
<tr>
<td>3</td>
<td>Major Diabetes w Ketoacidosis</td>
</tr>
<tr>
<td>4</td>
<td>Extreme Diabetes w Hyperosmolar Coma</td>
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<table>
<thead>
<tr>
<th>Risk of Mortality</th>
<th>Secondary Diagnosis-Cardiac Dysrhythmias</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minor Premature Beats</td>
</tr>
<tr>
<td>2</td>
<td>Moderate Sinoatrial Node Dysfunction</td>
</tr>
<tr>
<td>3</td>
<td>Major Paroxysmal Ventricular Tachycardia</td>
</tr>
<tr>
<td>4</td>
<td>Extreme Ventricular Fibrillation</td>
</tr>
</tbody>
</table>
What is a Hierarchial Condition Category (HCC)?

- CMS launched in 2004
- Used to help establish a payment model for Medicare insurers (MA Plans)
- These are grouped clinical diagnoses
  - Coronary Artery Disease
- Subcategories of conditions under CAD: AMI → CAD
  - Descending order of severity and cost expectations
What is a Hierarchial Condition Category (HCC)?

- Info comes from IP hospital, OP hospital, physician or NPP medical record
  - Collected once a year and reported to CMS
  - MAP paid based on severity, quality
  - Better capture of “highly weighted HCCs” means more $ paid to the MAP
MAP (or insurer) and HCC

- Better HCC capture → more revenue
- Watch useless spending → higher profit
- “Shared Savings”
  - Profits are “shared” with the provider (doctor or healthcare system)
  - Physicians who are poor coders may get de-selected from plans as the HCC capture is such a large component to insuring sustainability of insurer
Example of Clinically Correct Coding (Diabetes)

- 67 yo with longstanding DM (x 14 yr), on oral med, well controlled (A1c 6.9). She has stable findings on exam: numbness to light touch mid feet distally bilaterally. Has a h/o Glaucoma that started 8 yrs after DM diagnosed.
- How do you code....?
Example of Clinically Correct Coding (Diabetes)

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  1. DM w neurologic manifestations (250.60)
  2. DM with polyneuropathy (357.2)
  3. DM with ophthalmic manifestations (250.50)
  4. DM with glaucoma (366.41)
Physician Compensation/CMS

- Future will be to pay for quality achievement and cost containment
- Severity of illness/risk will be a part of calculation
  - “my patient’s are sicker”
  - ….SRHS’ latest numbers
- Learn how to *code correctly*
ICD-10 Timeline

- “Don’t teach too soon”
  - You should have started…don’t “go cold” (“CMS is quiet”)
- Billing “end to end testing” with TPA and Clearinghouses
- Inpatient strategy
  - Documentation Improvement Teams
  - Flyers, emails, “pop-ups” at dictation stations
  - Web-based learning
  - IP doctors MAY BE OK…but CDI team/coders may have issues in “searching for info to code”
- Outpatient strategy
  - Much different due to lack of front line support
  - Specialty specific “cross-walks’ to insure “top 100” primary care, “top 10 money makers” in surgery
    - Ease of use, make sure staff aware – TEAM EFFORT here for sure!!
ICD-10 will allow us to correctly define conditions

- Each specialty needs to create CHEAT SHEETS: “Long lists” and “Short lists” of the most commonly used codes
- [cms.gov](http://cms.gov) has free programs with GEMS (general equivalence mappings)
- [ICD10data.com](http://ICD10data.com)
- AAPC has specialty specific crosswalks, others…
- Must use I-10 correctly to capture the severity and specificity of the condition
- Much more granularity with I-10
We get more granularity with 10

- W5922XA: Struck by a turtle, initial
- W5922XD: ..............subsequent
- W5921XA: Bitten by a turtle, initial
- W5921XD: ..............subsequent
- W22.02XA: Walked into lamppost, initial
- W22.02XD: ..............subsequent
- V91.07XA: Burn due to water skis on fire, initial
- V90.27XA: Drowning and submersion due to falling/jumping from burning water skis, initial
Closing…..

- Embrace the change that is coming
- Use it to your advantage
- Don’t consider being suited for the ICD-10 code:
  - F63.3
F63.3
F63.3

Trichotillomania
Connect with me...

- Thank you!!

- Nick Ulmer, MD CPC
- 864-684-4248 (text/cell)
- nick.ulmer@prtcnet.com
Clinical Examples
Cardiac

- 67 year old seen for atrial fibrillation. Bursts of paroxysmal a-fib have been noted on recent holter. He is symptomatic. Several medication adjustments have been made and you have seen the patient 4 times this month.
Cardiac ICD-9

- Atrial fibrillation 427.31
- Atrial flutter 427.32
Cardiac

- **Atrial fibrillation**  427.31
  - Paroxysmal atrial fibrillation  I48.0
  - Persistent atrial fibrillation  I48.1
  - Chronic atrial fibrillation  I48.2
  - Unspecified atrial fibrillation  I48.91

- **Atrial flutter**  427.32
  - Typical atrial flutter  I48.3
  - Atypical atrial flutter  I48.4
  - Unspecified atrial flutter  I48.92
Cardiometabolic ICD-10: CP

- Chest pain is now
  - CP on breathing R07.1
  - Precordial CP R07.2
  - Pleurodynia R07.81
  - Intercostal pain R07.82
  - Other chest wall pain R07.89
  - CP, unspecified R07.9
Hypertension is:

- Borderline BP w/o hypertension R03.0
- Unspecified hypertension I10
- Benign essential hypertension I10
- Malignant essential hypertension I10
- ...due to renal disease I15.1
- ...due to endocrine (pheo) I15.2
Cardiometabolic ICD-10: HF

- HF is:
  - HF, unspecified  I50.9
  - LV failure  I50.1
  - Acute systolic CHF  I50.21
  - Chronic systolic CHF  I50.22
  - Acute on chronic systolic CHF  I50.23
  - Acute diastolic CHF  I50.31
  - Chronic diastolic CHF  I50.32
  - Acute on chronic diastolic CHF  I50.33
Diabetes mellitus

- Significant Change to Diabetes Mellitus
- There are six (6) Diabetes Mellitus categories in the ICD-10 - CM
  - E08  DM due to an underlying condition
  - E09  DM that is chemical or drug induced
  - E10  DM Type I
  - E11  DM Type II
  - E13  Other specified DM
  - E14  Unspecified DM
Diabetes mellitus

- Diabetes codes were expanded to include the classification of the diabetes and the manifestation.
- Category for diabetes mellitus has been updated to reflect the current clinical classification of diabetes.
- No longer is controlled or uncontrolled.
  - E08.22  DM due to underlying condition with diabetic chronic kidney disease
  - E09.52  DM, drug or chemical induced, with diabetic peripheral angiography with gangrene
  - E10.11  DM I, with ketoacidosis with coma
  - E11.41  DM II, with diabetic mononeuropathy
  - E11.311 DM II with unspecified diabetic retinopathy with macular edema
Orthopedics

- Fracture codes require seventh character to identify if fracture is open or closed
- The fracture extensions are:
  - A Initial encounter for closed fracture
  - B Initial encounter for open fracture
  - D Subsequent encounter for fracture with routine healing
  - G Subsequent encounter for fracture with delayed healing
  - K Subsequent encounter for fracture with nonunion
  - P Subsequent encounter for fracture with malunion
  - S Sequelae
- S42.022-Displaced fracture of shaft of left clavicle initial encounter for closed fracture
- Requires 7th character A for initial encounter — S42.022A
Clavicle fracture

- 24 choices for clavicle fracture in ICD-10
  - Only 1 in ICD-9
- Documentation must include
  - Laterality
  - Type (displaced) and if anterior or posterior
  - Location: sternal end, shaft, lateral end, unspecified
  - 7\textsuperscript{th} digit extender: A, B, D, G, K, P, S
- S42.001B: anterior displaced fracture of sternal end of R clavicle, initial ov, open fracture
Pathologic Fractures

- ICD-10 has 3 different categories for pathologic fractures
  - Due to neoplastic disease
  - Due to osteoporosis
  - Due to other unspecified disease
Breast Cancer

- 54 choices for male/female breast
- Documentation must include:
  - Laterality
  - Location
  - Use of an additional code to identify estrogen receptor status
- Example: C50.422 Malignant neoplasm of upper-outer quadrant of the left male breast
Surgery Coding

- Large and small intestine procedures
- 26 options in ICD-10
- Documentation must include
  - Specific site
    - Appendix, caput coli, cecum, colon and rectum, ascending, caput, descending, distal, left, right, sigmoid, pelvic, etc., etc. . .
  - C18.5 Malignant neoplasm of splenic flexure
Concussion

- Not all characters may be needed
- S06.0x0A
  - “A” is initial encounter
  - “D” would be subsequent
  - “S’ would be related to sequelae
Underdosing, RA

- A patient is prescribed prednisone for RA but stops taking the medication due to financial hardships. Due to the abrupt discontinuation, secondary adrenal insufficiency occurs.
- E27.40 Unspecified adrenocortical insufficiency
  - First listed as is event that is triggered or prolonged due to this circumstance
- T38.0x6 Underdosing of glucocorticoids
  - Secondary code assignment
- Z91.120 Intentional underdosing due to financial hardship
  - This additional code explains why the patient is not taking medication
ICD-10 implementation

- Areas of cost concern
  1. Education of physicians and staff
  2. Process analysis for needed flow change
  3. Modification of code sets to paper tracking(superbills)
  4. IT upgrades
    - 29 different applications at SRHS that must be enhanced
  5. Increased documentation issues
  6. Cash flow slow-down due to slowness of system to pay and appeals/denials
ICD-10 Timeline

- “Don’t teach too soon”
  - No worries about that now….need to have started
- Billing “end to end testing” with TPA and Clearinhouses
- Inpatient strategy
  - Documentation Improvement Teams
  - Flyers, emails, “pop-ups” at dictation stations
  - Web-based learning
  - IP doctors MAY BE OK…but CDI team/coders may have issues in “searching for info to code”
- Outpatient strategy
  - Much different due to lack of front line support
  - Specialty specific “cross-walks’ to insure “top 100” primary care, “top 10 money makers” in surgery
  - Ease of use, make sure staff aware – TEAM EFFORT here for sure!!
Effective physician training

- Utilize real, practical examples (specialty specific)
- Compare the difference in verbiage between ICD-10-CM and ICD-9-CM
- Create templates
- Distribute handouts, crosswalk “nuggets” not bolders
- Leverage newsletters
- Hang posters throughout the facility for awareness
- Hand out “pocket cards” for quick reference
- Media assisted learning coupled with live venues
Final thoughts...

- Find other systems ahead of you and learn
  - Healthcare intelligence software, crosswalks, etc.
- Support the providers as they are “the hand that feeds you”
  - Computer Assisted Software
  - Educate to their level on their terms
  - Staff additions up front (flex staffing) before too late
- Specificity can lead to better capture of risk/severity and help with CMI and better report cards/$$$
We get more granularity with 10

- W5922XA  Struck by a turtle, initial
- W5922XD  ..........subsequent
- W5921XA  Bitten by a turtle, initial
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- V90.27XA  Drowning and submersion due to falling/jumping from burning water skis, initial
We get more granularity with 10

- Hit/struck by object due to accident in a
  - Merchant ship – initial, subsequent, sequelae
  - Passenger ship…
  - Fishing boat…
  - Power watercraft…
  - Sailboat…
  - Canoe/kayak…
  - Non-powered watercraft…
  - Unspecified watercraft…
Hopefully you won’t qualify for:

- X73.2XXA
  - Initial encounter of an individual seeking to do self harm with the use of a machine gun
Go Fly a Kite.......... 

- Whirlpool Gorge at Niagara Falls, 1848
  - 800 feet wide, 225 feet high, shear cliffs, roaring rapids
- Had to cross, but how to cross....?
- Homan Walsh, 15 year old
Thank you!

Contact me:

864-684-4248 (cell)
NUlmer@ProTimeLLC.com
nick.ulmer@prtcnet.com
Question #1

- The correct maximum number of characters for ICD-10 is
  1. 5
  2. 7
  3. 9
  4. 10
  5. The same as ICD - 9
Question #2

General Equivalence Mapping tools (GEMs) are defined as

1. Maps that show equivalent DRG weights between ICD-9 and ICD-10 codes
2. Anatomic maps of body areas that are equivalent in ICD-10 code sets
3. Linkage tools that align two code sets without consideration of context or documentation
4. Tools that perfectly match ICD-9 and ICD-10
5. The temporary bridge coders use to understand medical decision making in ICD-10
Question #3

The best way to show non-compliance in ICD-10 coding is

1. No code exists for “non-compliance”
2. The 200 series, which indicates “medication mismanagement”
3. The J200 code series, indicating “situations outside of the control of the physician”
4. The “underdosing” code series
5. The L code set, which typifies “Loser”
Question #4

- The seventh (7th) character in ICD-10
  1. Notes the left or right side of the body
  2. Indicates the patient is non-compliant with medications
  3. Shows that a patient is from an underserved population
  4. Defines the type of visit, i.e., initial or subsequent
  5. Is recommended in all code sets
Question #5

The External Causes of Morbidity Code Set

1. Are mandated by CMS nationally and are required on all injuries, but not on acute or chronic visits
2. Will be required in 2015, but are optional now
3. Are voluntary to be coded on office visits unless mandated by your state
4. Are the J200 code set mentioned in the Affordable Care Act
5. Have automatic “hard stops” built in so clearinghouses will pay at a higher rate
Thank you!

Contact me:

864-684-4248 (cell)

NUlmer@ProTimeLLC.com

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The record reflects severity, intensity and medical necessity through the documentation of diagnoses and procedures.

CPT codes are not used.
ICD – 9 and 10

The codes speak the language of the diseases being managed in an encounter

Three important concepts

1. Severity of illness
2. Risk of mortality
3. Complication or Comorbid conditions
The importance of documentation

- Risk of mortality and severity of illness realized through the selection of:
  - Principal Diagnosis
  - Secondary Diagnoses
  - Procedures Performed
Impact: Physicians and Hospitals

- To know the impact, we need to understand a bit about the basics to coding and documentation.
The Challenge

Physician Documentation is recorded in CLINICAL terms and symptoms

Documentation for coding & compliance must contain specific DIAGNOSTIC terms and defined disease states

The Answer: Clinical Documentation Improvement
Understanding SOI and ROM

Severity of illness and risk of mortality are largely dependent on the patient’s underlying problems.

High Severity of Illness and Risk of Mortality are characterized by multiple serious diseases and the interaction among those diseases.
Secondary Diagnoses

What diagnoses do the coders code?
Additional conditions that affect patient care in terms of requiring at least one of the following (the baggage):

- Clinical evaluation, OR
- Therapeutic treatment, OR
- Diagnostic procedures, OR
- Extend length of hospital stay, OR
- Increase nursing care and/or monitoring
All Interrelated Conditions that Impact Patient Care

**BILIARY TRACT DISORDERS**
- Acute Cholangitis
- Acute Pancreatitis
- Sepsis

**SKIN ULCER**
- Etiology (PU, DM)
- Cellulitis
- Osteomyelitis
- Sepsis

**TRAUMA**
- Hypovolemia/hypoxemia
- Acute blood loss anemia
- Acute respiratory failure/ARDS
- Septic Shock

**DIVERTICULAR DISEASE**
- Abscess
- Obstruction
- Sepsis/SIRS

**Link comorbid conditions as appropriate:**
- PVD due to DM
- HTN and CAD as HCVD
<table>
<thead>
<tr>
<th>Common Secondary Diagnoses Affecting Severity of Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis</td>
</tr>
<tr>
<td>Stage III or IV decubitus</td>
</tr>
<tr>
<td>Pneumonia</td>
</tr>
<tr>
<td>Ulcer or gastritis w/hemorrhage</td>
</tr>
<tr>
<td>Acute or A/C renal failure</td>
</tr>
<tr>
<td>Acute or A/C respiratory failure</td>
</tr>
<tr>
<td>Diabetic ketoacidosis (DKA)</td>
</tr>
<tr>
<td>Acute or A/C systolic or diastolic HF</td>
</tr>
</tbody>
</table>
Severity of Illness (SOI) defined

The extent of physiologic decomposition, organ system loss of function, and/or mortality.

Refers to:
- How sick is the patient?
- How difficult is the patient to manage?
- What types of interventions are required?
- What is the intensity of resources utilized?
Risk of mortality (ROM) defined

An estimate of the likelihood of in hospital death for a patient.

*Risk-Adjusted Mortality*: The ratio of observed mortality rate (actual mortality) to severity-adjusted (or risk-adjusted) expected mortality rate.

Mortality index = \( \frac{\text{Observed mortality}}{\text{Expected mortality}} \)

- **Observed mortality** is driven by quality-of-care initiatives
- **Expected mortality** is driven (in large part) by documentation of secondary diagnoses.
## Documentation Guidelines: Heart Failure

<table>
<thead>
<tr>
<th>Documented Diagnosis</th>
<th>High Severity</th>
<th>Moderate Severity</th>
<th>Low Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive heart failure “CHF”</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Rheumatic heart failure</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Left heart failure</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Unspecified systolic and/or diastolic heart failure</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Chronic systolic and/or diastolic heart failure</td>
<td></td>
<td></td>
<td>X</td>
</tr>
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<td></td>
<td></td>
<td>X</td>
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<td></td>
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How are Severity and Risk of Mortality Measured?

By documenting secondary diagnoses!

<table>
<thead>
<tr>
<th>Severity of Illness</th>
<th>Secondary Diagnosis-Diabetes Mellitus</th>
</tr>
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<tbody>
<tr>
<td>1 Minor</td>
<td>Uncomplicated Diabetes</td>
</tr>
<tr>
<td>2 Moderate</td>
<td>Diabetes w Renal Manifestation</td>
</tr>
<tr>
<td>3 Major</td>
<td>Diabetes w Ketoacidosis</td>
</tr>
<tr>
<td>4 Extreme</td>
<td>Diabetes w Hyperosmolar Coma</td>
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How are Severity and Risk of Mortality Measured?

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<td>Diabetes w Hyperosmolar Coma</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk of Mortality</th>
<th>Secondary Diagnosis-Cardiac Dysrhythmias</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Minor</td>
<td>Premature Beats</td>
</tr>
<tr>
<td>2 Moderate</td>
<td>Sinoatrial Node Dysfunction</td>
</tr>
<tr>
<td>3 Major</td>
<td>Paroxysmal Ventricular Tachycardia</td>
</tr>
<tr>
<td>4 Extreme</td>
<td>Ventricular Fibrillation</td>
</tr>
</tbody>
</table>
CC and MCC: Secondary dx that affects severity

**CC:** Complication/Comorbidity
**MCC:** Major Complication/Comorbidity

**CC = Complication/Comorbidity**
A condition that, when present, leads to substantially increased hospital resource use:
- Significant acute disease
- Acute exacerbation of significant chronic disease
- Advanced or end-stage chronic diseases
- Chronic diseases associated with extensive deilities
Case Mix Index

- Score derived from the clinical documentation (ICD)
- Indicates the intensity of services and resources needed to care for the patient
- “sicker” should be “higher” if we document correctly
- CMI x $$$ assigned to facility = DRG
MS-DRG Structure-CV Surgery

- **Heart Valve Procedures**
  - DRG 218 w/o CC/MCC $34,284
  - DRG 217 with CC $40,743  \text{Difference $6,459}}$
  - DRG 216 with MCC $61,081  \text{Difference $20,338}}$

- **Major Chest Procedures**
  - DRG 165 w/o CC/MCC $11,500
  - DRG 164 with CC $16,806  \text{Difference $5,306}}$
  - DRG 163 with MCC $32,849  \text{Difference $16,043}}$
MS-DRG Structure-Medical

- **Simple Pneumonia**
  - DRG 195  w/o CC/MCC $4,541
  - DRG 194  with CC $6,414  Difference $1,873
  - DRG 193  with MCC $9,556  Difference $3,142

- **Complex Pneumonia**
  - DRG 179  w/o CC/MCC $6,287  Difference $1,746
  - DRG 178  with CC $9,242  Difference $2,955  Difference $2,828
  - DRG 177  with MCC $13,185  Difference $3,943  Difference $3,629

- **CHF**
  - DRG 293  w/o CC/MCC $4,332
  - DRG 292  with CC $6,438  Difference $2,106
  - DRG 291  with MCC $9,736  Difference $3,298

*Simple to Complex PNA
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Specifics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>• Vessels accessed</td>
</tr>
<tr>
<td></td>
<td>• Source of vein/artery</td>
</tr>
<tr>
<td></td>
<td>• Implanted device</td>
</tr>
<tr>
<td>Debridement (not I&amp;D)</td>
<td>• Excisional vs. non-excisional</td>
</tr>
<tr>
<td></td>
<td>• Deepest tissue layer debrided</td>
</tr>
<tr>
<td>Removal/Repair/Replace</td>
<td>• New vs Repeat</td>
</tr>
<tr>
<td></td>
<td>• Revision vs Replace</td>
</tr>
<tr>
<td></td>
<td>• Source of device</td>
</tr>
<tr>
<td></td>
<td>• Residual material/device</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>• Delivery vs Extraction</td>
</tr>
</tbody>
</table>
Impacts on American Healthcare

- Providers and hospitals
  - We are being watched ("graded")
  - Hospital Compare
Hospital Compare

- Created with CMS and Hospital Quality Alliance (HQA) in 12-02
  - Public/private collaboration
  - Allow consumers to make informed decisions
  - Improve quality
- 2008: HCAHPS added as part of “grade”
  - Also 30d mortality for MI, HF, pneumonia added
Providers and hospitals

- We are being watched ("graded")
- Hospital Compare
  - Consumer oriented website providing info for how well hospitals provide care
  - Pit one hospital to another, small/large hospitals are weighted compared to what they do
  - MI, HF, pneumonia, surgery, etc.
- Organized by:
  - Patient Survey (HCAHPS)
  - Clinical measures: timely care, readmissions, Medicare volume, complications, deaths
Hospital Compensation

Value-based purchasing

- Starts with a “withhold”
- Metrics are derived from data submission (not self reported like some consumer benchmarking tools)
  - If records don’t coincide with CMS audit (90%), then hospital forfeits the chance to get back withhold
- Budget neutral: ½ American hospitals win, ½ lose
- Healthcare systems have $1-2M in play
Impacts on American Healthcare

Providers and hospitals
- We are being watched ("graded")
- Hospital Compare
- Physician Compare
Physician Compare

- Mandated by the Affordable Care Act (ACA)
  - Launched 12 – 2010
  - Continual re-design since inception
  - Two-fold purpose:
    1. Consumer information to make educated decisions
    2. Create incentives to physicians to maximize performance
- First planned quality data to be uploaded 2014 (PQRS, eRx, EHR based)
- First planned patient experience data (CG CAHPS) is to be uploaded for ACOs and group practices of >100 EPs ASAP but not before 2014.
Medicare Spending Per Beneficiary Measure (MSPB)

  - Combination of resource utilization and quality
    - Target best outcomes for best cost
    - Efficiency model of care with hopes to improve value of care
- Assessed Part A and B “per Beneficiary” episode of care over period of 9 mo (5-15-2010 → 2/14/11)
- CMS will define resources, but will look at snapshots of care from 3d prior to admission to 30d after
  - Measure is adjusted for age and SOI
- CMS will develop a ratio of spend
  - 1 is ~average, <1 is less spend (good), and > 1 is more spend (bad)
Impacts on American Healthcare

- Providers and hospitals
  - Financial concerns
    - CMS states 1 in 5 practices will see denials *double* for six months after 10-01-2014
      - Report estimated cost per practice to implement ICD-10
ICD-10-Procedural Coding System (PCS)

- Developed by CMS
- First version was released in 1998
- Replaces ICD-9-CM Volume 3
- No WHO procedure code set – unique to U.S.
- Only used for hospital inpatient coding – does not replace CPT in the outpatient settings
ICD-10-PCS (procedures)

ICD-9-CM (procedures)

ICD-10-PCS (procedures)

0FB03ZX - Excision of liver, percutaneous approach, diagnostic

0DQ10ZZ - Repair, upper esophagus, open approach