

Analyzing the Financial Impact of ICD-10

Practical Considerations to Minimize Losses in Productivity, Cash flows and Profits, and Mitigate Risk for Compliance

CPAS / ADVISORS



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Mitigate Risk....Documentation Challenges With ICD-10

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Primary ICD-10 Impact

- Three Primary Sections:
 - Operations & IT
 - Reimbursement Impact
 - **Documentation & Coding**

Documentation

- Documentation drives everything.....
- coding...claims
- submission.....
- reimbursement.....
- revenue.....
- organization health

Common Documentation Problems

- Inadequate physician documentation in both inpatient and outpatient settings to support the extra level of specificity required by ICD-10
- Symptoms, signs and/or working diagnoses were coded when a definitive diagnosis has been established (outpatient)
- Physician orders lack level of specificity necessary for ICD-10 (outpatient)
- All coexisting conditions documented by physician are not being reported (outpatient)
- Unspecified diagnosis codes and specified diagnosis codes of a condition or injury were reported
- Illegible physician handwriting
- All inpatient procedure codes not being reported

Inpatient/Outpatient

Coding/Documentation Review Summary

- Physicians are using abbreviations that are not based off the standardized list of abbreviations
- Outpatient encounter/order forms lack the level of specificity necessary for ICD-10
- Co-existing conditions, documented by physician, were not coded
- Diagnosis code assignments were not always assigned to their highest degree of specificity
- Lack of supporting physician documentation to support diagnosis coded and billed
- Signs/symptoms were code when a definitive diagnosis had been established
- Procedure was coded but the documentation did not support that the procedure was performed

Inpatient/Outpatient

Coding/Documentation Review Summary

- Inadequate physician documentation in both inpatient and outpatient settings to support the extra level of specificity required by ICD-10
- Co-existing conditions, documented by physician, were not coded
- Handwritten documentation was difficult to interpret due to illegible handwriting and/or illegible notations

Example

- Example: **Physician documents partial small bowel resection with no further specificity** To code the appropriate root operation ICD-10 for the procedure being performed, physician documentation needs to identify the exact portion of the small intestine that was removed. If the physician documents removal of an entire portion of ileum or jejunum for example, this would then be coded to resection instead of excision.
- MS-DRG Reimbursement Impact: (\$6,261.27)

Physician Practice

- Physician documentation was not specific enough for the assignment of ICD-10 codes resulting in the assignment of miscellaneous, non-specific diagnosis codes.
- Co-existing conditions, documented by physician, were not coded
- Lack of supporting documentation to support the codes (CPT & E/M)
- Handwritten documentation was difficult to interpret due to illegible handwriting and/or illegible notations
- EMR-cloned documentation

Clinical Documentation Improvement

- Expand CDI program to include all patient discharges preparing for ICD-10 and Pay-for-Performance
- Provide formal education and training to acquire CCDS/CDIP certification
- Continue to leverage CDI Measure metrics and identify opportunities/trends
- Include ICD-10 specific metrics in monthly dashboards as education begins
- Engage Physician Advisor(s)
- Increase staffing resources
- Collaboration/Increased interaction with HIM due to ICD-10
- Maximize ICD-10 Education & Training Opportunities
- Coder Career Ladder
- Computer-Assisted Coding System

Critical Success Factor:
Productivity Mitigation
Streamline Quality
Limit Learning Curve
Enable dual-processing environment

What Can You Do

- Educate practitioners on what they need to document for ICD-10
- Not interested in learning the coding right now
- For the condition, what do they need to specify in their patient encounter
- KISS principle—Keep it Simple

What Can You Do

- Train coders earlier—not later
 - We need to monitor documentation
- **Documentation translates to revenue**
- **Perform ICD-10 Readiness Audits Quarterly—Education is Key**

A layman's view of the impact to your ambulatory operations

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 Laura DeBusk
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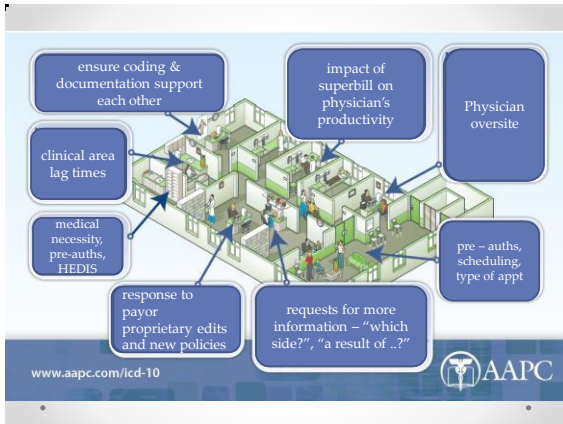
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The worst that can happen?

new technology
 new documentation requirements
 new coding conventions
 requests for clarifying information



physician's productivity negatively impacted



- learning curve for documentation / coding
- significant increase in questions, clarifications
- oversight for all policy and procedure changes, quality reporting
- do-overs for pre-authorizations
- new rules for medical necessity
- hunting and pecking through drop-downs, learning new descriptions / syntax
- loss of muscle memory with new forms / formats
- cash flow degradation

Coding Increase by Specialty

Specialty	ICD-9 Codes	ICD-10 Codes	Coding Increase
Cardiology	178	430	2.5 x
Dermatology	172	603	3.5 x
OB-GYN	220	777	3.5 x
Family Practice	229	829	3.6 x
Ophthalmology	204	848	4.2 x
Pediatrics	165	836	5 x
Orthopedics	143	5,843	40.9

Source: White Plume Technologies, 2012

ICD-10 Superbill – American Academy of Family Practice

Family Practice Management Superbill Template
For use by family practice physicians and other qualified health care providers. For more information, visit www.aafp.org/education/continuingeducation/medicare

ICD-10 Code	ICD-10 Description	ICD-10 Code	ICD-10 Description
710.00	Arthritis, unspecified	710.01	Arthritis, unspecified, right hip
710.02	Arthritis, unspecified, left hip	710.03	Arthritis, unspecified, bilateral hip
710.10	Gonorrheal arthritis	710.11	Gonorrheal arthritis, right hip
710.12	Gonorrheal arthritis, left hip	710.13	Gonorrheal arthritis, bilateral hip
710.20	Septic arthritis, unspecified	710.21	Septic arthritis, right hip
710.22	Septic arthritis, left hip	710.23	Septic arthritis, bilateral hip
710.30	Staphylococcal arthritis	710.31	Staphylococcal arthritis, right hip
710.32	Staphylococcal arthritis, left hip	710.33	Staphylococcal arthritis, bilateral hip
710.40	Pneumococcal arthritis	710.41	Pneumococcal arthritis, right hip
710.42	Pneumococcal arthritis, left hip	710.43	Pneumococcal arthritis, bilateral hip
710.50	Other streptococcal arthritis	710.51	Other streptococcal arthritis, right hip
710.52	Other streptococcal arthritis, left hip	710.53	Other streptococcal arthritis, bilateral hip
710.60	Arthritis due to other bacteria	710.61	Arthritis due to other bacteria, right hip
710.62	Arthritis due to other bacteria, left hip	710.63	Arthritis due to other bacteria, bilateral hip
710.70	Recurrent gout	710.71	Recurrent gout, right hip
710.72	Recurrent gout, left hip	710.73	Recurrent gout, bilateral hip
710.80	Chronic gout	710.81	Chronic gout, right hip
710.82	Chronic gout, left hip	710.83	Chronic gout, bilateral hip
710.90	Acute gout	710.91	Acute gout, right hip
710.92	Acute gout, left hip	710.93	Acute gout, bilateral hip
711.00	Septic arthritis, unspecified	711.01	Septic arthritis, right hip
711.02	Septic arthritis, left hip	711.03	Septic arthritis, bilateral hip
711.10	Septic arthritis, unspecified	711.11	Septic arthritis, right hip
711.12	Septic arthritis, left hip	711.13	Septic arthritis, bilateral hip
711.20	Septic arthritis, unspecified	711.21	Septic arthritis, right hip
711.22	Septic arthritis, left hip	711.23	Septic arthritis, bilateral hip
711.30	Septic arthritis, unspecified	711.31	Septic arthritis, right hip
711.32	Septic arthritis, left hip	711.33	Septic arthritis, bilateral hip
711.40	Septic arthritis, unspecified	711.41	Septic arthritis, right hip
711.42	Septic arthritis, left hip	711.43	Septic arthritis, bilateral hip
711.50	Septic arthritis, unspecified	711.51	Septic arthritis, right hip
711.52	Septic arthritis, left hip	711.53	Septic arthritis, bilateral hip
711.60	Septic arthritis, unspecified	711.61	Septic arthritis, right hip
711.62	Septic arthritis, left hip	711.63	Septic arthritis, bilateral hip
711.70	Septic arthritis, unspecified	711.71	Septic arthritis, right hip
711.72	Septic arthritis, left hip	711.73	Septic arthritis, bilateral hip
711.80	Septic arthritis, unspecified	711.81	Septic arthritis, right hip
711.82	Septic arthritis, left hip	711.83	Septic arthritis, bilateral hip
711.90	Septic arthritis, unspecified	711.91	Septic arthritis, right hip
711.92	Septic arthritis, left hip	711.93	Septic arthritis, bilateral hip
712.00	Old tear LCL	712.01	Old tear LCL, right hip
712.02	Old tear LCL, left hip	712.03	Old tear LCL, bilateral hip
712.10	Old tear ACL	712.11	Old tear ACL, right hip
712.12	Old tear ACL, left hip	712.13	Old tear ACL, bilateral hip
712.20	Old tear PCL	712.21	Old tear PCL, right hip
712.22	Old tear PCL, left hip	712.23	Old tear PCL, bilateral hip
712.30	Old tear MCL	712.31	Old tear MCL, right hip
712.32	Old tear MCL, left hip	712.33	Old tear MCL, bilateral hip
712.40	Old tear ICL	712.41	Old tear ICL, right hip
712.42	Old tear ICL, left hip	712.43	Old tear ICL, bilateral hip
712.50	Old tear LCL/ACL	712.51	Old tear LCL/ACL, right hip
712.52	Old tear LCL/ACL, left hip	712.53	Old tear LCL/ACL, bilateral hip
712.60	Old tear LCL/PCL	712.61	Old tear LCL/PCL, right hip
712.62	Old tear LCL/PCL, left hip	712.63	Old tear LCL/PCL, bilateral hip
712.70	Old tear ACL/PCL	712.71	Old tear ACL/PCL, right hip
712.72	Old tear ACL/PCL, left hip	712.73	Old tear ACL/PCL, bilateral hip
712.80	Old tear LCL/MCL	712.81	Old tear LCL/MCL, right hip
712.82	Old tear LCL/MCL, left hip	712.83	Old tear LCL/MCL, bilateral hip
712.90	Old tear LCL/ACL/PCL	712.91	Old tear LCL/ACL/PCL, right hip
712.92	Old tear LCL/ACL/PCL, left hip	712.93	Old tear LCL/ACL/PCL, bilateral hip
713.00	Internal derangement	713.01	Internal derangement, right hip
713.02	Internal derangement, left hip	713.03	Internal derangement, bilateral hip
713.10	Recurrent instability	713.11	Recurrent instability, right hip
713.12	Recurrent instability, left hip	713.13	Recurrent instability, bilateral hip
713.20	Effusion hip	713.21	Effusion hip, right hip
713.22	Effusion hip, left hip	713.23	Effusion hip, bilateral hip
713.30	Villonodular degeneration	713.31	Villonodular degeneration, right hip
713.32	Villonodular degeneration, left hip	713.33	Villonodular degeneration, bilateral hip
713.40	Enthesopathy	713.41	Enthesopathy, right hip
713.42	Enthesopathy, left hip	713.43	Enthesopathy, bilateral hip

Coding and documentation

Requires new information

Tells a more detailed story

x	Lower/Knee/Hip	Other Information	Rank & Link	Written Notes	Typed Notes
	KNEE CONT'D				PELVIS/HIP/FEMUR
717.81	Old tear LCL				711.05 Septic arthritis hip
717.82	Old tear MCL				
717.83	Old tear ACL				
717.84	Old tear PCL				
717.9	Internal derangement				
718.36	Recurrent instability				
719.06	Effusion hip				
719.26	Villonodular degeneration				
726.60	Enthesopathy				

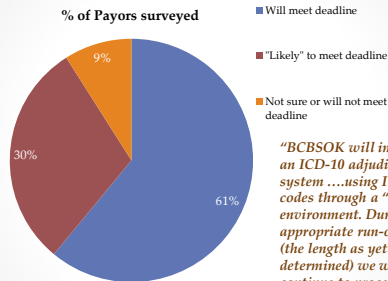
ICD-10 Scenarios	
Choose a Diagnosis	
M00.059	Staphylococcal arthritis, unspecified hip
M00.159	Pneumococcal arthritis, unspecified hip
M00.259	Other streptococcal arthritis, unspecified hip
M00.859	Arthritis due to other bacteria, unspecified hip

GEMS is Incomplete

- Approximate Code Example - 1 ICD-10 code required
- 754.30 – Congenital Hip Dislocation
 - Q65.00 – Congenital Dislocation of unspecified hip, unilateral
- Problem:
 - ICD-10 allows for greater specificity in this example by introducing laterality. GEMS converts this code only to the unspecified unilateral ICD-10 code, which will not always be correct.
- 754.30 – Congenital Hip Dislocation
 - Q65.00 – Congenital Dislocation of unspecified hip, unilateral
 - Q65.01 – Congenital Dislocation of right hip, unilateral
 - Q65.02 – Congenital Dislocation of left hip, unilateral
 - Q65.1 – Congenital Dislocation of hip, bilateral
 - Q65.2 – Congenital Dislocation of hip, unspecified

Payor readiness for ICD-10

% of Payors surveyed



Source: HealthEdge survey, 2012

"BCBSOK will implement an ICD-10 adjudication systemusing ICD-10 codes through a "Pure" environment. During an appropriate run-out period (the length as yet not determined) we will continue to process ICD-9 claims through our existing environment."

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What's on your Payors' Plate?

Adjudication

- Continual changes to payment policies (Denials)
- Backwards mapping from ICD-10 to ICD-9 / Improper payments, carve outs
- Managing commercial, WC and auto claims

Operational changes

- System changes and associated issues
- Slow downs in every area
- Increased demands on help lines and provider relationship managers

Contracting

- Lack of meaningful historical data for contracting with ICD-10

Policy changes

- Pre-authorizations and referral
- Medical necessity
- Proprietary edits
- Coverage policies and formularies
- Appeals and Timely filing – especially for claims prior to the cut off

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Payor Proprietary (Black box) Edits

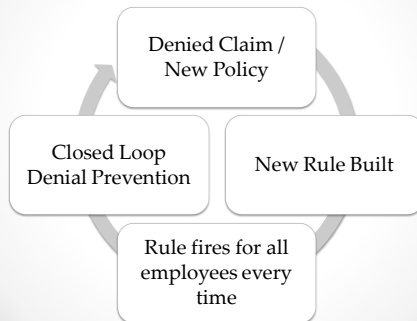
	Aetna	Anthem	Cigna	HCSC	Humana	Regence	UHC
Payer-specific edits	62,335	76,726	1,190	123	5,033	5,000	82,868

Source - AMA 2012 National Health Insurer Report Card

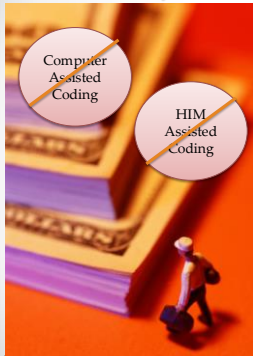
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Closed Loop Denial Prevention



Which tools do you need for ambulatory RCM?



- eSuperbill that **preserves muscle memory**
- **flexible tools** that support both WC and HIPAA claims
- **closed loop denial prevention** process
