Lessons learned in the aftermath of ICD-10

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• Nancy Enos, FACMPE, CPC-I, CPMA, CEMC, CPC
• Mike Enos, CPC, CPMA, CEMC
Nancy Enos, FACMPE, CPMA, CEMC, CPC-I, CPC, is an independent consultant and coding instructor with 35 years of operations experience in the practice management field. She joined Ingenix (formerly LighthouseMD) in 1995 and served as the Director of Physician Services until July 2008.

As an Approved PMCC Instructor of the American Academy of Professional Coders, Nancy provides coding certification courses, outsourced coding, chart auditing, consultative services and seminars in CPT and ICD-9 coding, evaluation and management coding and documentation, and compliance planning. Nancy frequently speaks on coding, compliance and reimbursement issues to audiences from the provider community specializing in primary care and surgical specialties.

Nancy is a Fellow of the American College of Medical Practice Executives. She is on the ACMPE Advancement Committee of MGMA and is a past president of MA/RI MGMA. She is the founding president of the Rhode Island Chapter, AAPC.
Mike Enos, CPC, CPMA, CEMC has over 10 years’ experience in medical coding, billing compliance and revenue cycle management, and has developed a suite of online training courses on Evaluation and Management, ICD-10, and CPC preparation.

After earning a B.A. from Rhode Island College, Mike pursued three professional medical coding certifications, including Certified Professional Coder (CPC), Certified Professional Medical Auditor (CPMA), and Certified Evaluation and Management Coder (CEMC). Mike’s experience with public speaking and education adds a unique perspective to the CPC training courses offered by Nancy Enos, FACMPE, CPC-I, CPMA, CEMC.

Mike has contributed articles to MGMA Connection Magazine and presented at MGMA Conferences, AAPC chapter meetings and the New England Quality Care Alliance (NEQCA) Fall Forum. He has served as a billing compliance specialist with Medsafe, and he currently works as a compliance consultant with Enos Medical Coding.
Agenda

• Ease the disruption caused by ICD-10

• Review tips and tricks learned in the aftermath of ICD-10

• Learn how to minimize disruptions caused by Oct. 1
Disruption

• The change from ICD-9 to ICD-10 demanded greater specificity in provider documentation
• Staff members need ICD-10 codes to perform tasks, such as prior authorizations, booking surgery, and billing
• New workflows that may include orders to outside providers will require ICD-10 codes for diagnostic or therapeutic services
• Charge lag time will affect billing cycles
  – Estimated 10% to 15% decline in productivity
  – Estimated declining reimbursement and increased denials
Tips and tricks

• Review your top 50 codes and make cheat sheets
  – Work with your specialty society or the AMA

• Don’t overthink the changes
  – Many CPT coding questions have come up as a result of the change
  – CPT coding and reimbursement policies based on CPT remain the same
  – Focus on the basics: location, laterality, clinical details
Common questions

- Preventive examinations
- Bilateral codes
- Code sequencing
- 7th character extenders
- How many diagnoses should be assigned
- Use of unspecified codes
## Annual preventive exam codes

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z00.00</td>
<td>Encounter for general adult medical examination without abnormal findings</td>
</tr>
<tr>
<td>Z00.01</td>
<td>Encounter for general adult medical examination with abnormal findings</td>
</tr>
<tr>
<td></td>
<td>(use additional code(s) to report abnormal findings)</td>
</tr>
<tr>
<td>Z00.121</td>
<td>Encounter for routine child health examination with abnormal findings</td>
</tr>
<tr>
<td></td>
<td>(use additional code(s) to report abnormal findings)</td>
</tr>
<tr>
<td>Z00.129</td>
<td>Encounter for routine child health examination without abnormal findings</td>
</tr>
<tr>
<td>Z01.411</td>
<td>Encounter for gynecological examination with abnormal findings</td>
</tr>
<tr>
<td></td>
<td>(use additional code(s) to report abnormal findings)</td>
</tr>
<tr>
<td>Z01.419</td>
<td>Encounter for gynecological examination without abnormal findings</td>
</tr>
</tbody>
</table>

Many questions stem around guidance for “with and without” abnormality because many coders have not been able to find any guidance regarding what “with abnormal findings" means.
It depends on when the abnormality is found

- The physician is doing a well child exam and finds the child with a diaper rash – doesn’t bill separately for it – but it was identified during the PE. Does the provider bill “with abnormal findings”?
- Yes, following guidance from the AAFP that, “Diagnosis codes for abnormal findings may be reported regardless of whether the finding requires an additionally reported service”
- Remember, the ICD-10 codes are informational and are not intended to drive any changes in reimbursement
- For this case, report:
  - 9939X dx Z00.121 and dx L22 (diaper rash)

Chronic, stable conditions

- The physician is doing a well child exam and reviews the child’s asthma history. Patient fills out an act form, is stable without any exacerbations and doesn’t even need a refill on the meds. Although the physician will NOT be billing for the asthma, other than a PFT/oximetry, should the physician bill for “with abnormal findings”?

- This has to do more with stable chronic conditions … if it is stable – but addressed briefly (not enough to bill a “separately identifiable service”) – you bill “stable chronic conditions” as “without” abnormal findings

- 9939X dx Z00.129 For this example, report no abnormal findings; the patient had an established condition
General medical exam

• Z00.00 Encounter for general adult medical examination without abnormal findings is the “new” code to replace V70.0.

• Also, Z00.01 is informational to report encounter for general adult medical examination with abnormal findings. (Use additional code to identify abnormal findings.)

• This does not affect billing. The rules stay the same: bill 99391-99397 for established patients and 99381-99387 for new patients for general medical examinations, based on age.
General medical exam

- The CPT rules are not changed with the implementation of ICD-10. The rules for billing a “sick visit” on the same day as a “preventive visit” require:

  - Significant and separately identifiable services (documentation of the sick visit) was performed on the same day as the physical. If both are 1) medically necessary and 2) documented separately, no “double dipping,” then add Modifier -25 to the Evaluation and Management Code (reporting the “sick visit” with 99201-99205 or 99211-99215).
Tip

• Use the “with abnormal findings” codes only when an abnormality is discovered during a routine exam.
Laterality and bilateral codes

• A common misconception is that HCPCS Modifiers – LT, RT and CPT Modifier 50 – will not longer be required, because the ICD-10-CM codes indicate laterality.

• Remember, the ICD-10-CM codes reports which side is affected.

• The CPT codes report which side is treated.
Code sequencing

• The ICD-10-CM manual provides extensive instruction, usually in red text, on sequencing.

• Codes that have an underlying cause, such as an infection or systematic disease, are reported second – after their cause is identified.

• Additional codes for “status” such as dialysis, substance abuse (tobacco, alcohol, drugs) and risk factors such as obesity, are reported after the principal diagnosis.
Diabetes and CKD example

• Type 2 Diabetes Mellitus with End Stage Renal Disease
  – E11.22 Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease
  – N18.6 End Stage Renal Disease
  – Z99.2 Dialysis Status
Tips

• Code first any:
  – Diabetic chronic kidney disease
  – Hypertensive chronic kidney disease
    • Use additional code to identify kidney transplant status, if applicable Z94.0
    • ESRD use additional code to identify dialysis status Z99.2

• Code based on the reason for the encounter
  – A patient in end stage renal disease is admitted to undergo dialysis. The patient is prepared and fitted for a peritoneal dialysis catheter, and dialysis is performed in the outpatient hospital dialysis center.
    • Z49.02 Encounter for fitting and adjustment of peritoneal dialysis catheter
    • N18.6 End stage renal disease, chronic kidney disease requiring chronic dialysis
7th character extensions

- Used to report the episode of care
- Don’t drive the code selection
- Used throughout the course of treatment
7th character extensions

• All codes in Chapter 19 and many codes in Chapter 20 require 7th character codes to report the status of an injury.
• These 7th character rules are often confused with the “status” rules for CPT codes.
• They are not related at all. CPT guidelines address episodes of care, such as “new” or “established” patients.
• 7th character extensions report the status of the injury, providing information about the course of treatment.
7th character extensions

- “A” active care (defined in the manual as “initial”)
- “D” routine or recovery care (defined in the manual as “subsequent”)
- “S” sequela
Active treatment and aftercare

• Extension “A,” initial encounter, is used while the patient is receiving active treatment for the injury. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

• Initial encounter is while receiving active treatment.
  – Surgical treatment
  – Emergency treatment
  – E/M by a new provider
  – Those who seek delay for treatment of a nonunion or fracture
Active treatment and aftercare

- Extension “D,” subsequent encounter, is used for encounters after the patient has received active treatment of the injury and is receiving routine care for the injury 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 including physical therapy, and follow-up visits following injury treatment.
  - The aftercare Z codes should not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with the seventh character “D” (subsequent encounter).
Active treatment and aftercare

• Extension “S,” sequela, is for use for complications that arise as a direct result of an injury, such as scar formation after a burn. The scars are sequela of the burn.
• When using extension “S,” it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself.
• The “S” is added only to the injury code, not the sequela code.
• The “S” extension identifies the injury responsible for the sequela.
• The specific type of sequela (e.g., scar) is sequenced first, followed by the injury code.
V97.33XXD: How the heck can you get sucked into a jet engine more than once?

- A common misconception about the 7th character extensions in ICD-10 is the use of the A, D or S extensions on the External Causes of Morbidity, such as “V97.33 Sucked into jet engine.”

- This category of codes requires a seventh character to report the episode of care. “A,” initial encounter; “D,” subsequent encounter; or “S,” sequela.
Iron Man

• Let’s say that a person was actually sucked into a jet engine and went to the Emergency Department with a fractured ankle. Otherwise, he had only minor superficial injuries. (Did I mention the patient is Iron Man? No, that would be a HIPAA violation.)

• Primary diagnosis: S82.51XA Displaced fracture of the medial malleolus of the right tibia, initial encounter

• Second diagnosis: V97.33XA Sucked into jet engine, initial encounter
Iron Man

• The patient is whisked away to the Emergency Department where Dr. Derek “McDreamy” Shepherd repairs the fractured ankle, applies a cast and sends the patient home. Two weeks later, Iron Man arrives at Dr. Shepherd’s office for an X-ray and cast check. He’s recovering amazing well (of course).

• Primary diagnosis: S82.51XD Displaced fracture of the medial malleolus of the right tibia, subsequent encounter

• Second Diagnosis: V97.33XD Sucked into jet engine, subsequent encounter

• So, the A, D or S explains where the patient is in the course of the treatment and recovery from the injury.

• The subsequent extension “D” is not intended to report multiple, identical injuries!
Tip

• Do not confuse the CPT definition of a “new” versus “established” patient when choosing the 7th character extension.
• The purpose of the 7th character extension is to indicate where the patient is in the course of treatment for an injury.
• For physical therapy, the treatment plan is active (A) but once performing the modalities of treatment plan, then it is subsequent or “routine” (D).
• Remember, the guidelines are vague and the 7th characters are not tied to payment.
• It is possible that a person was doing well and a provider reported “D” and now needs to switch back to “A” when the plan of care needs to be adjusted.
Code all documented conditions

- The documentation should support all diagnoses reported.
- Be sure to code any other complications or comorbidities that are present at the time of the encounter and are either being treated or are factoring into the treatment of the patient.
  - Don't over-code by including every diagnosis the patient has ever had; make sure the diagnosis is relevant.
- Code all documented conditions that coexist. Just as in ICD-9, the official guidelines for ICD-10 instruct us to “code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management.”
  - Do not code conditions that were previously treated and no longer exist.
  - However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
“Unspecified” codes

• In both ICD-9-CM and ICD-10-CM, sign/symptom and unspecified codes have acceptable, even necessary, uses. While you should report specific diagnosis codes when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, in some instances, signs/symptoms or unspecified codes are the best choice to accurately reflect the healthcare encounter.

• You should code each healthcare encounter to the level of certainty known for that encounter.
“Unspecified” codes

• If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.

• When sufficient clinical information is not known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate unspecified code (for example, a diagnosis of pneumonia has been determined, but the specific type has not been determined).

• In fact, you should report unspecified codes when such codes most accurately reflect what is known about the patient’s condition at the time of that particular encounter.

• It is inappropriate to select a specific code that is not supported by the medical record documentation or to conduct medically unnecessary diagnostic testing to determine a more specific code.
“Unspecified” codes

You will never be asked to provide more detail than is medical necessary to treat the patient.

• Exact model of aircraft, unspecified
• Brands of drinks served, unspecified

• Airport, unspecified
• Flight time, unspecified
• Destination, unspecified
Signs and symptoms

- Just as in ICD-9-CM, codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.
- Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.
- Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.
Minimize disruptions

• During the first 3 weeks of ICD-10 billing, providers, clearinghouses and payers are keeping a close eye on claims with ICD-10 codes.

• Early reports are very positive.

• Scrutinize denials carefully.
Documentation watch

- The detail reported in the ICD-10 codes must be supported by the provider’s notes.
- Review documentation closely and provide feedback.
- Consider internal audits.
- Payment policies have not changed significantly.
  - Under ICD-9 we used “unspecified codes” where appropriate. For instance, a patient leaves a physician office with a diagnosis of pneumonia. At this point, the physician does not have more information on the cause.
  - ICD-9 481 Pneumonia converts to J18.1 Lobar pneumonia, unspecified organism.
Documentation watch

• Watch for “highly utilized” codes.
  – Is your provider using E11.9 for a default for all Type II Diabetes?
  • Payers will change payment edits based on trends.
  • Payers will be lenient at first to allow for a “learning curve,” but don’t get complacent.
  – Payers will set up auditing/review based on codes submitted frequently.
Post-implementation action

• Review and watch:
  – Productivity levels
    • Providers documentation and coding
    • Billers charge entry and claims submission
  – Level of pended claims
    • Is your PM system holding claims with edits that are more stringent than required?
  – ICD-10 issues other than charges
    • Denials related to authorization number or referrals
  – Days in A/R
  – Payment amount
CMS transition period

- In July, CMS announced changes to help ease the transition to ICD-10, including:
  - One-year transition period for providers to familiarize themselves with the diagnosis codes
    - Claims will not be denied when the ICD-10 code is from the correct “family” of codes.
  - Lifted penalties for the Physician Quality Reporting System
  - Advanced physician payments if contractors have ICD-10-related issues processing claims
  - New CMS communication center to help monitor and resolve issues
CMS guidance for submitting ICD-9 and ICD-10

• ICD-9 codes will no longer be accepted on electronic or paper claims with “from” dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after October 1, 2015. Institutional claims containing ICD-9 codes for services on or after October 1, 2015, will be returned to provider (RTP).
• Professional and supplier claims containing ICD-9 codes for dates of services on or after October 1, 2015, will also be returned as unprocessable.
  – You will be required to re-submit these claims with the appropriate ICD-10 code.
• A claim cannot contain both ICD-9 codes and ICD-10 codes.
  – Medicare will RTP/return as unprocessable.
• For dates of service prior to October 1, 2015, submit claims with the appropriate ICD-9 diagnosis code.
• For dates of service on or after October 1, 2015, submit with the appropriate ICD-10 diagnosis code.
Payer updates

• After two weeks, payers were reporting a very low ICD-10 claim rejection rate
  – Humana: 0.3%

• As of Oct. 1, 2015, there were four state Medicaid agencies not ready to accept ICD-10 claims
  – CA, LA, MD, MT

• 26 state worker’s compensation carriers are not planning to convert to ICD-10
What does the future hold?

• ICD-10 is already under revision.

• Annual updates will begin on Oct. 1, 2016.

• The implementation date for ICD-11 is expected to be in 2018.
  – Remember, ICD-10 implementation was delayed 3 times, in 2009, 2012 and 2014.
The good news!

• The long-term benefits
  – Improved analytics based on increased specificity
  – More accurate reimbursement

• Clinical documentation improvements
  – Notes will support medical necessity.
  – Notes will support level of service.
    • Many code descriptions include location and etiology that will improve the History of Present Illness and Review of Systems.
  – Continue to audit charts to be sure the details in the ICD-10 codes are supported by your notes.
Y2K all over again?

“Even if you’re on the right track, you’ll get run over if you just sit there”

- Will Rodgers

• The first few weeks of ICD-10 are progressing nicely according to the top payers in the country; however, there is much work before we can all say we are done.

• Continue your “post-implementation” through the next year and beyond.
Helpful websites

National Center for Health Statistics
  - http://www.cdc.gov/nchs/about/major/dvs/icd10des.htm

CMS
  - http://www.roadto10.org/

AHIMA
  - http://www.ahima.org/icd10

MGMA
  - www.mgma.com

AAPC
  - www.aapc.com

AMA
Questions?