Did we “plan” enough?

- Created lead people and involved in the entire project:
  - Billing
  - Tech team
  - Pre-certification/authorization team
  - Administrator (or Operations)

- After training, we used “Sampled visits” from our EMR to compare documentation
  - Given a visit and the ICD-9 diagnoses …
    - What would the ICD-10 code be?
    - Would that new/different answer result in changes to WHAT they charted?
    - Important that they saw the “before” and “after”
    - Staff needed to understand WHY so that changes they made would “stick”

Year ONE….

- Since October 1, 2015 a recent survey showed that 80% of medical practices felt that the ICD-10 transition was successful
- The most commonly cited issues nationally were with clinical documentation, coding education, and coding / revenue cycle delays
- Before ICD-10, the denial rate for claims was around 1.5%.
- Post ICD-10 only slight increase noted (to 1.75%)
- So in spite of 155,000 + ICD 10 codes …
  - “Y2K” mess did not happen
  - But we did work HARD to lessen impact
Why did we do OK?

■ In analyzing our roll-out, it was critical to identify the KEY performance indicator to assess progress
  - Identify ALL possible issues in cash flow
  - Would OUR system be an issue?
■ Testing, Testing, Testing!
■ Open lines of communication with EMR, PM vendors
  - And KEEP THEM OPEN
■ Clearinghouse issues?
  - Did they test? Were there issues?
  - What if there were no payments to the practice?
  - What about “interrupted” payments?
  - How long?

■ Develop the Operational Metrics for impact of ICD-10
  - Monitor days from service date to bill date
  - Analyze impact on AR
  - Days to payment
  - Did payments match expected?
  - Other – did same payers come through and others NOT?
  - Coder productivity
  - How many claims per hour?
  - Frequency of claims sent back to doctor or clinical staff for documentation clarification
  - We found this to be a source of significant delay; we don’t file until this was completed.

Clinical Metrics

■ Chart documentation
■ Impact on clinical quality measures
  - Create a consistent way that staff can communicate with you on coding issues, create an ICD-10 INTERNAL group email list, a “cheat sheet” form in each lane
  - How can you best distribute new information; share coding challenges. Make it fun!
  - Anatomy knowledge by scribes/coders is more important now. We used supervisor input to see individual and departmental weaknesses and trained to those.
  - Some information was still NEW to everyone. Example:
    - ICD 10 has codes for visual disturbances that ICD 9 did not provide (dry/bulldozer, glare; decreased contrast)
    - Look at the H53 section

■ Percentage of denials
  - Remember they are a financial drain
■ Cost to get the funds already due
■ Tread the course(s)
■ Fix the issue, stay on top of it

■ Cash flow: If you generated $200,000 daily in revenue in ICD 9 days and are now at $150,000 … there is a huge problem!

What now?

■ Watch the use of unspecified codes! They should be rare.
■ Ask for staff feedback on which codes are most difficult for them—
■ Training must be on-going. Make it FUN!
■ Perform internal audits – who is selecting the codes – physician, technician or your EMR?
■ Does the medical record support the ICD 10 code selected?
■ Have you purchased 2016 coding books?
  - Keep your resources and tools up to date!
■ Review 7th character use(s)
  - A= initial encounter defined as “initial encounter for the injury or condition while the patient is receiving active treatment – surgery, ER encounter, and evaluation and treatment by a new physician
  - D= subsequent care defined as “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
  - S= Sequela, defined as “use for complications or conditions that arise as a direct result of an injury, such as a scar or other late effect of the initial injury”

Financial Metrics
Combination codes

- Train staff on use of combination codes and conditions that require the stage
- Such as: Diabetic codes require stage to be documented as mild, moderate or severe
- Also with or without edema
- Example for 2016: E10.349= Type 1 Diabetes with severe non-proliferative retinopathy without edema
  - Proposed changes for 10/01/2016:
    - Laterality for existing diabetic retinopathy codes, laterality w/PDR combined w/ RD codes
    - Laterality and stage for both AMD and OAG
- Stage unspecified should only be used if provider uncertain of stage or waiting on results of diagnostic testing
- In ICD 9, codes classified as retinal detachments and breaks
- In ICD-10, it is "and breaks" and then further broken down by single, multiple and unspecified number of breaks

Retinal breaks

- In ICD 9 codes classified retinal detachments and breaks, now it is "and breaks" and then broken down by single, multiple and unspecified number of breaks
  - "And" means and/or
- Coder could easily default to "unspecified number of breaks" if providers fail to provide detail in charts
- Are your scribes trained to "code in the lane" at time of charting and to record the best ICD 10 code when scribing
  - EMR can help!

Value Based Payment Model

- Traditional fee for service models are going away, to be replaced by VBP model
  - Rapidly changing to a "MIPS" model as VBP quickly disappears
- Pre-determined performance goals that incentivize physicians are cropping up
- Documentation and accuracy in utilization of ICD 10 codes will be critical
- Data collected over next several years will feed into
  - Measurement of patient care outcomes
  - Policy development
  - Pay for performance initiatives
  - Justification for medical necessity

Bottom line

- Document, Document, Document – simply state in the record patient condition(s) in detail—we do this, just improve it!
- Prove by your chart notes medical justification for treatments; diagnostic testing. Link a diagnosis to test being performed– interpret the test!
- Code by specificity and laterality
- If H code does not apply – determine what does
  - Simple, right?!
- Not everything will be an H code
  - Once away from "H", you might see "Unspecified"

ICD 10 CMS update

- The ICD 10 Coordination & Maintenance Committee, along with the Centers for Medicare & Medicaid Services, at the committee’s first meeting since 10/1/2015, announced plans for implementing its first update on 10/1/16.
- They will be adding an additional 1,900 new diagnosis codes
- You can submit proposals for new codes to CDC at icd10@cdc.gov
- The committee meets next in September. Include in proposal description of code change request; rationale for code with clinical relevance; any supporting documentation to support the code.
- Go to CMS.gov/ICD10 and take advantage of resources that are available

Take a step back..

- Assign or re-assign an ICD 10 project manager
- Review your workflow
- Claim rejection audits
- Quarterly ICD 10 meetings to include project manager; billers; coders; IT person; scribes
- Train the trainers!
Vigilance!

- Work with your EMR vendor - test your coding software in your EMR
- Coders must refresh clinical knowledge - understand ocular anatomy and general medical terminology
- Providers need to be retrained also, make them aware of coding delays due to failure in documentation which equals potential revenue delay or loss
- Create Top 10 or Quick lists in EMR to speed up code selection
- Practice training plan must be an active on-going process

Level of Training

- Determine the level of training for staff - they all will not require same type and level of training
- Meet the educational needs of each group
- Everyone within the practice would need awareness training, What is ICD 10, how does it differ from ICD 9; impact on their day to day jobs on the ICD 10 flow. This can be group training; short meeting time
- Next level is intense training - this would be applicable to the doctors; clinical staff; managers; coders; billers. More detailed training on code structure.

It’s NEVER really over ...

- Next level is extensive training; for staff involved in reimbursement processes - coders; billers; administrators; managers; scribes; compliance officer - must understand all aspects of ICD 10 flow and revenue cycle and have frequent on-going training.
- Don’t assume all is going well - Stay involved; test the processes; challenge your team.
- Use the PROCESS

Coding and Documentation: Impacts of ICD-10

- There were multiple delays
  - Originally Oct 2013, then delay to Oct 2014
  - Oct 2015 - this last was a “surprise”
  - Contingency planning (for the delay itself)
  - Were these truly sunk costs?
  - Were there some benefits?
- Each new deadline created a need to move the timetable back and decide if training would cease, pause, or slow-down
- MU and PQRS Concerns
  - ICD-10 “Code freeze” is lifted Oct 1 2016, so new codes and options can be implemented.

What did we learn?

- Roll-out was not without issues
- Provider problems
  - Not going to ICD-10 at all
  - Unspecified code issues
  - Issues understanding the “Leniency” provisions
    - Doesn’t apply when a guidance document exists
  - All ICD-9 LCD’s went to “retired” status and some were not re-issued

- Inability to code from chart notes
- Insufficient (or too many) digits
- Nonsensible “invented” code
  - e.g., Choosing laterality when inappropriate
- Incompatible codes or code order
  - Excludes1, Excludes2
  - Code First, Use Additional Code instructions
- Undesirable code use
  - Unspecified or other nonspecific code used (Does not match chart specifics)
- Missing co-morbidities, implants, grafts coding
What did we learn about ourselves?

- Payer issues
  - Failure to correctly map the covered ICD-9 codes into ICD-10
  - Old coverage guidance issues leading to improper assumptions
    - Ex: Brow ptosis already did not have a good choice in ICD-9
- Payer omits some codes in the new policy
  - 362.53 (CME) and 362.07 (DME) both had ICD-9 coverage
    - H59.03: omitted
- Diabetic retinopathy codes (E10, E11) ending in "1" (with ME) are omitted but the ending "9" (without ME) are included

What did we learn?

- Laterality (for some but not others)
  - Why was AMD not given laterality but the less-common ERM was?
  - Diabetic retinopathy?
    - Eyelid vs eye laterality
      - Did not match our E modifiers!
      - 0 or 9 for "unspecified"?
      - There is a system but it seems somewhat arbitrary (what position is the 0 or 9 in?)
- Combination coding
- Seventh character?
  - A, D, S
  - Glaucoma staging
  - "X" placeholders (sometimes more than just "one x")
- Combination coding
- Seventh character?
  - A, D, S
  - Glaucoma staging
  - "X" placeholders (sometimes more than just "one x")

Mapping Issues

"Laterality"

- ICD-9 code = 366.16
  - Under: Senile Cataract
  - Nuclear sclerosis
- ICD-10: Right, Left, and Bilateral designations
  - 1 = right
  - 2 = left
  - 3 = bilateral
  - 0 or 9 = unspecified
- Example:
  - H25.11: Age-related nuclear cataract, right eye
  - H25.12: Age-related nuclear cataract, left eye
  - H25.13: Age-related nuclear cataract, bilateral
  - H25.10: Age-related nuclear cataract, unspecified eye
- H02.011: Cicatricial entropion of right upper eyelid
- H02.012: Cicatricial entropion of right lower eyelid
- H02.013: Cicatricial entropion of right eye, unspecified eyelid
- H02.014: Cicatricial entropion of left upper eyelid
- H02.015: Cicatricial entropion of left lower eyelid
- H02.016: Cicatricial entropion of left eye, unspecified eyelid
- H02.019: Cicatricial entropion of unspecified eye, unspecified eyelid

Terminology

"Laterality"

- H02.011: Cicatricial entropion of right upper eyelid
- H02.012: Cicatricial entropion of right lower eyelid
- H02.013: Cicatricial entropion of right eye, unspecified eyelid
- H02.014: Cicatricial entropion of left upper eyelid
- H02.015: Cicatricial entropion of left lower eyelid
- H02.016: Cicatricial entropion of left eye, unspecified eyelid
- H02.019: Cicatricial entropion of unspecified eye, unspecified eyelid

PQRS and MU

- One year grace period with no denials based on specificity as long as ICD-10 code is from appropriate “family of codes”
- No penalty with quality programs (PQRS, VBM, MU) as long as appropriate “family of codes is used”
- “Leniency” (grace) period ends on 9/30/16, so your PM needs to be able to read current ICD-10 as well as possible proposed “new” codes that begin use October 2016 and match to appropriate uses

Will ICD-10 change again? Yes!

- Code “freeze” lifted
- New proposed codes - Effective 10/01/16
- 260 new diabetes combination codes for reporting manifestations
  - Laterality for diabetic eye disease
  - New diabetic eye disease options
- Laterality for AMD and Open-Angle Glaucoma
- Staging for AMD
- Chapter 19 changes

Source: Centers for Disease Control, Decision Health (Both on March 22, 2016)
### ICD-10 Update?

**ICD-10 (Now)**
- H35.31 (Dry AMD)
- H40.11x2 (Mod St OAG)
- E11.329 (Type II DM, Mild NPDR, no DME)

**ICD-10 (Proposed 10/01/16)**
- H35.31 (Non-exudative AMD, Intermediate stage, OD)
- H40.1122 (Mod St OAG, OS)
- E11.3293 (Type II DM, Mild NPDR, no DME, Bilateral)
- E11.3532 (Type II DM, PDR, Traction RD not involving macula, OS)

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### ICD-10 Update?

**ICD-10 (Now)**
- H40.11x2 (Mod St OAG)

**ICD-10 (Proposed 10/01/16)**
- H35.3112 (Non-exudative AMD, Intermediate stage, OD)
- H35.3122 (Non-exudative AMD, Intermediate stage, OS)
- E11.3293 (Type II DM, Mild NPDR, no DME, Bilateral)
- E11.3532 (Type II DM, PDR, Traction RD not involving macula, OS)

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### ICD-10 Update?

**ICD-10 (Now)**
- E11.329 (Type II DM, Mild NPDR, no DME)

**ICD-10 (Proposed 10/01/16)**
- E11.329 (Type II DM, Mild NPDR, no DME)
- Important difference:
  - Not like AMD/Glaucoma
  - EYE is 7th character
  - Some new PDR codes (RD, etc)
  - E11.3293 (Type II DM, Mild NPDR, no DME, Bilateral)
  - E11.3532 (Type II DM, PDR, Traction RD not involving macula, OS)

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### You did it – and you could do it again!

(if you had to...)

- Thanks!
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