ICD-10 AND HIPAA V5010

The Power Is In The Presentation…

Presenter: Beverlyjean K Jenkin, LA, CMM, CPM, CPM-HRS, COM, CPC, CPM-MCS, CPMA

VP, Healthcare Operations
Health Informatics Consulting

Attitude

- Charles R. Swindoll once wrote “We cannot change the inevitable,” and stated that he was “convinced that life is 10% what happens to me and 90% how I react to it.”

Compliance

- Healthcare payers, providers and pharmaceutical companies are facing two major compliance initiatives; the conversion from HIPAA V4010 to V5010 electronic transaction sets; and, the conversion from ICD9 to ICD10 code sets.

5010 Protocols

Implementation Issues for Providers

- NPI reporting –

  Report lowest level of enumeration for Billing Provider

  Report the same level of enumeration to all trading partners

Implementation Issues continued…

- 9 - digit ZIP requirement for Billing Provider and Service Facility Location
- Changes to anesthesia time reporting

  Report minutes only; no units
- Changes to AMT segments

Implementation Issues continued

- Requires calculation for some amounts
- Patient – subscriber reporting changes
- Report patient in subscriber loop if they have a unique payer identifier

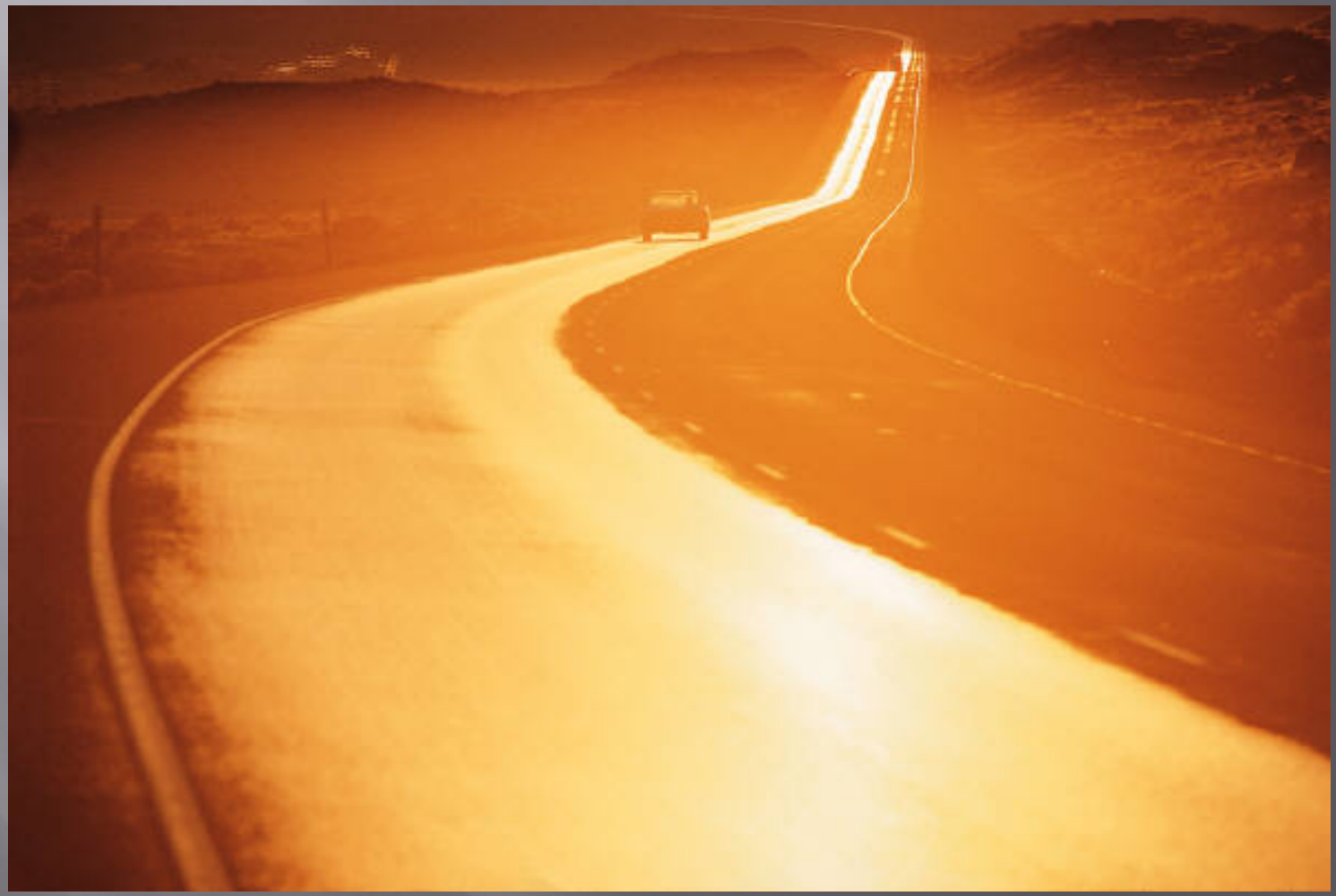
National Version 5010 Testing Day

- CMS has announced that Wednesday, June 15th, 2011 will be National Version 5010 Testing Day. CMS states that HIPAA-covered entities should be taking steps now to get ready, including conducting external testing to ensure timely compliance. Non-compliance with 5010 after the January 2012 deadline could impact payer reimbursement.

Medicaid Participation in National 5010 Testing Day

- National 5010 Testing Day will allow an opportunity for providers and clearinghouses to test compliance efforts that are already being utilized, with the benefit of real-time help desk support, and with the benefit of direct and immediate access to MACs (Medicare Administrative Contractors). Several state Medicaid agencies will be participating in the National 5010 Testing Day.

The Road To Change



V5010 Conversions

- The U. S. Department of Health and Human Services (HHS) announced that healthcare organizations must transition to an electronic environment and update standards for electronic healthcare and pharmacy transactions, including professional and institutional claims 835 remittance advices eligibility claims status requests and responses.

V5010 Implementation Steps

- Step 1:

- Perform a gap analysis to determine a compliancy timeframe.

- Identify current 4010 formats and pharmacy transactions.

V5010 Implementation Steps continued…

- Identify the differences between 4010 custom guidelines an 5010 standard guidelines.
- Develop a matrix for conversion work.
- Establish measurable goals and objectives for compliancy.
- Estimate and plan a budget for 5010 resources, timing and fiscal planning.

V5010 Implementation Steps continued…

- Coordinate efforts with ICD-10 to avoid duplication of efforts and work.
- Develop a communication plan.

V5010 Implementation Steps continued…

- Step 2:
- Execute the migration to 5010.
- Update processes and maintenance protocols.
- Finalize testing and success criteria.

V5010 Implementation Steps continued…

- Set-up and coordinate "go live" plans with business partners.
- Coordinate use of 5010 as a pre-requisite for ICD-10 sets.

V5010 Conversions continued…

- The new HIPAA standard 5010 includes more specific directions for EDI (electronic data interchange) claims. These new formats provide many changes to the current 4010A version such as modified subscriber and hierarchy, clarification of pay-to-provider usage, clarification of Coordination of Benefits (COB), and refined reversal and corrections instructions.

V5010 Implementation Steps continued…

- Step 3:
- Develop a 5010 testing plan.
- Perform a "go live" dress rehearsal.
- Test new formats with vendors.

V5010 Implementation Steps continued…

- Step 4:

- Train affected users and develop new processes to accommodate expanded business needs.

V5010 Implementation Steps continued…

- Step 5:

- Ensure adequate staffing for "go live" and transition period.

Who Will Be Affected?

Everyone

HEALTH PROFESSIONALS
Physicians - documentation
Nurses – forms
Clinical Staff - authorizations

MANAGERS
New Policies and Procedures
Vendor and Payer Contracts
Budgeting
Training Plans

BILLING/CODING
Policies and Procedures
Training
Concurrent Use (ICD9 and ICD10)

ADMINISTRATIVE STAFF
HIPAA
Systems for patient encounters

LABORATORIES
Documentation
Reporting

HHS Statement

- The Department of Health and Human Services (HHS) released a 2009 statement estimating the cost of conversion from ICD-9 to ICD-10 at between $849 million and $3.00 billion dollars. They also stated that people, operations and technology will be greatly impacted.

Code Set Comparisons

- ICD-9 has 24,000 codes
- ICD-10 will have over 69,000 codes

- ICD-9 inpatient procedure codes number almost 4,000
- ICD-10 inpatient procedure codes number 72,000

- ICD-9 are 3 to 5 characters in length
- ICD-10 are 3 to 7 characters in length

- ICD-9 has limited space for new codes
- ICD-10 is flexible for adding new codes

Volumes

- ICD-9 is a two-volume set

- ICD-10 is a three-volume set -
  - **Volume 1:** Cause of Death
  - **Volume 2:** Descriptions, Guidelines, and Coding rules
  - **Volume 3:** Table of Drugs and Chemicals

Index

- There are 2 parts to the ICD-10-CM index –
  The table of drugs and injury
  The table of neoplasm's

- The former ”V” codes are now ” Z” codes contained in chapter 21, “Factors Influencing Health Status and Contact with Health Services.”

ICD-10 Format and Structure

- Alphanumeric 3 characters

Category

- 4 or 5 characters
- Etiology, Anatomical Site, Severity

Subcategory

- Up to 7 characters

Extension

Hierarchical Structure

- ICD-10-CM consists of 21 chapters.
- Some chapters include the addition of a sixth character.
- ICD-10-CM includes full code titles for all codes (no references back to common fourth and fifth digits).
- V and E codes are no longer supplemental classifications.
- Sense organs have been separated from nervous system disorders.
- Injuries are grouped by anatomical site rather than injury category.
- Postoperative complications have been moved to procedure-specific body system chapters.

Hierarchical Structure continued

- ICD-9 may have an alpha (E or V) or numeric first code, with numeric digits from the 2nd through the 5th digits
- ICD-10 has an alpha 1st code, numeric digits for the 2nd and 3rd, and digits 4 through 7 are alpha or numeric

- ICD-9 lacks details
- ICD-10 codes are very specific

- ICD-9 are non-specific and do not define diagnoses needed for research and data analysis
- ICD-10 improve specificity and allow for better research and data analysis

Hierarchical Structure continued

- ICD-9 does not support interoperability because they are not recognized in other countries
- ICD-10 supports interoperability and the exchange of health care information between the United States and other countries.

- ICD-9 does not support laterality (right or left)
- ICD-10 supports laterality (different codes for right and left)

ICD-10-CM Chapters 1-4

- *Chapter 1* – infectious and parasitic diseases (A00 – B99)
- *Chapter 2* – neoplasms (C00 – D49)
- *Chapter 3* – diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50 – D89)
- *Chapter 4* – endocrine, nutritional and metabolic diseases (E00 – E90)

ICD-10-CM Chapters 5-10

- *Chapter 5* – mental and behavioral disorders (F01 – F99)
- *Chapter 6* – diseases of the nervous system (G00 – G99)
- *Chapter 7* – disorders of the eye and adnexa (H00 – H59)
- *Chapter 8* – diseases of the ear and mastoid process (H60 – H95)
- *Chapter 9* – diseases of the circulatory system (I00 – I99)
- *Chapter 10* – diseases of the respiratory system (J00 – J99)

ICD-10-CM Chapters 11-16

- *Chapter 11* – diseases of the digestive system (K00 – K94)
- *Chapter 12* – diseases of the skin and subcutaneous tissue (L00 – L99)
- *Chapter 13* – diseases of the musculoskeletal system and connective tissue (M00 – M99)
- *Chapter 14* – diseases of the genitourinary system (N00 – N99)
- *Chapter 15* – pregnancy, childbirth and the puerperium (O00 – O99)
- *Chapter 16* – certain conditions originating in the perinatal period (P00 – P99)

ICD-10-CM Chapters 17-21

- *Chapter 17* – congenital malformations, deformations and chromosomal abnormalities (Q00 – Q99)
- *Chapter 18* – symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00 – R99)
- *Chapter 19* – injury, poisoning and certain other consequences of external cause (S00 – T88)
- *Chapter 20* – external causes of morbidity (V01 – Y98)
- *Chapter 21* – factors influencing health status and contact with health services (Z00 – Z99)

Placeholders

- ICD-10-CM utilizes dummy placeholder characters ("X").
- The "X" is used as the 5th digit placeholder in certain 6 character codes to permit future expansion.

Combination Codes for Poisonings and the External Cause

- Examples:

T39.011 - Poisoning by aspirin, accidental (unintentional)

T39.012 - Poisoning by aspirin, intentional self harm

T39.013 - Poisoning by aspirin, assault

T39.014 - Poisoning by aspirin, undetermined

Combination Codes

- Examples:

125.110 – Arteriosclerotic heart disease of native coronary artery with unstable angina pectoris

disease with chronic active hepatitis

K50.013 – Crohn's disease of small intestine with fistula

K71.51 – Toxic liver disease with ascites

Coding Case Examples

Benefits

- Ability for more accurate payments for new procedures
- Fewer rejected claims
- Less improper or fraudulent claims
- A better understanding of new procedures
- Improved disease management
- Codes can be grouped in a more logical fashion for ease of use

Pyelonephritis

Pyelonephritis due to sarcoidosis

- ICD-9: 135 and 590.00
- ICD-10: D86.84

Sickle Cell

- Sickle cell thalassemia with acute chest syndrome:
- ICD-9: 282.42, 517.3
- ICD-10: D57.411

Sarcoidosis

- Sarcoidosis with polyarthritis
- ICD-9: 135, 713.79
- ICD-10: D86.86

Spleen

- Accidental puncture due to exploratory laparotomy with excision of metastatic lesions peritoneal cavity –
- ICD-9: 197.6 and 998.2
- ICD-10: C78.6 and D78.12

Immunodeficiency

- Immunodeficiency due to hypoplasia of the thymus –
- ICD-9: 279.11
- ICD-10: 982.1

Around the World

International Communication

- A number of other countries are currently using ICD-10, including:

- United Kingdom – since 1995
- France - since 1997
- Australia – since 1998
- Germany – since 2000
- Canada – since 2001

Time Marches On

Compliance Deadlines

- V5010
  - Proposed - April 1, 2010
  - Final Date - January 1, 2012
  - Small health plans have an additional year to comply on January 1, 2013.
- ICD-10-CM
  - Proposed - October 1, 2011
  - Final Date - October 1, 2013

Ten Step ICD-10 Implementation Plan

- STEP 1:

  Organize for the implementation – Identify who will be responsible for the project, the team and the determinations regarding resources.

  Hire the experienced Consultant that will assist you with the implementation.

  Contact your system vendors to be sure they are ready and can accommodate the necessary changes. Make sure you have the necessary hardware to support the system. Check for any "hidden costs."

Establish a Communication Plan

- STEP 2:

  Decide how to communicate with the physicians and staff.

  Develop the materials to explain ICD-10 and how they will be disseminated.

  Work with your Consultant to establish your timelines.

Conduct an Impact Analysis

- STEP 3:

  Determine who and what systems will be impacted and where the practice gaps are.

  Review all regulations and requirements to be sure you will be in compliance.

  Identify how you will fund the transition.

Develop a Budget

- STEP 4:

  Formulate a hypothesis of costs to include –

  Software
  Hardware
  Implementation
  Upgrades
  Staff training

Vendor Strategies

- STEP 5:

  Address any issues identified in the gap analysis.

  Determine what level of support and what support period the vendor will provide.

  Address a timeline for the changes to take place.

  Determine when testing will occur and what the practice downtime may be.

Business Process Analysis and Policy Change Development

- STEP 6:

  Review the current coding processes of clinical, administrative and billing departments.

  Determine how auditing requirements will be met (a minimum of four times per year for external auditing for compliance is recommended).

Step 6 continued…

Identify which contracts have reimbursement(s) directly related to a particular diagnosis.

Perform contract negotiations.

Establish necessary policy changes and communicate same to physicians and staff.

Deployment of Code by Vendors to Customers

- STEP 7:

  Install the new software containing the ICD-9-CM mapping to ICD-10-CM on your system.

  Make all internal customizations and integrate the changes into the production systems.

  Test the system with clearinghouses and individual payer systems.

Develop a Training Plan

- STEP 8:

  The training plan should include –

  ICD-10-CM guidelines
  General code set training
  Regulatory issues
  Specialty specific code training

Outcomes Measurement

- STEP 9:
  - Measure coder productivity and quality
  - Re-evaluate the documentation
  - Perform internal audits regularly
  - Perform external audits quarterly
  - Provide continuing education and training

Implementation Compliance

- STEP 10:

  Must comply with the October 1, 2013 "Go Live" date.

  Review insurance carrier payment policies and make necessary adjustments.

  Resolve claims errors and denials.

Inpatient Coder Training

- The ICD-10-CM/PCS Final Rule estimates that inpatient coders will need 50 hours of training on ICD-10. These 50 hours presume that the coder possesses the required knowledge in anatomy, physiology, pathophysiology, pharmacology and medical terminology.

Inpatient Coder Training continued…

- The recommended breakdown for these hours is as follows:

  16 hours on ICD-10-CM (clinical modification of the classification for morbidity purposes), 24 hours on ICD-10-PCS (Procedural Coding System), and 10 hours on additional practice.

Outpatient Coder Training

- Outpatient coders who currently assign ICD-9-CM diagnosis codes must learn ICD-10-CM coding. The Final Rule estimates that approximately 16 hours will be required for this training.

- Outpatient coders may not be required to understand how ICD-10-PCS codes are used; however, they will also need to know anatomy, physiology, and clinical disease processes.

Resources

- https://www.cms.gov/ICD10/
- www.ahima.org/**icd10**
- www.aapc.com/**icd-10**
- NAMAS@NAMAS-Auditing.com
- http://www.aapc.com/ICD-10/codes

The Golden Rule

Remember…

IF IT IS NOT DOCUMENTED – IT DID NOT HAPPEN

Coding Tips

- Documentation:
- Must list the Chief Complaint, unless you are performing a preventive service.
- Only the HPI (History of Present Illness) must be documented by the physician.

Coding Tips continued…

- When determining a code based on Prolonged Service Time the start and stop time, spent face-to-face with the physician, must be documented in the chart.
- Pre-op clearance IS a consult – most carriers, with the exception of Medicare, still pay for consults.

Coding Tips continued…

- All other information can be obtained by the staff or on separate information sheets completed by the patient – provided they are reviewed and dated/initialed by the physician and made a permanent part of the medical record.

- The new Medicare Annual Wellness Visit can be performed by office medical staff, with a physician on premise.

Coding Tips continued…

- Examination:

- Body Areas –
- When documenting body areas each extremity counts separately (i.e. two arms examined equal two body areas counted).

- An examination can be based on the 1995 or the 1997 documentation guidelines.

Coding Tips continued…

- 1995 examinations are based on the body systems and areas.
- 1997 examinations are based on bullets outlined through the specific system examinations.
- The areas examined must be documented and each area must list the findings of the exam.

Coding Tips continued…

- Documentation that uses the words "negative" or "normal" meets the necessary documentation guidelines.
- You can use the statement "all other systems are negative."
- Exams that use words such as "unremarkable" or "non-contributory" do not meet the necessary requirements.

Coding Tips continued…

- Documentation that reveals an abnormal area will not constitute complete documentation unless the reason the exam was abnormal is also documented.

Coding Tips continued…

- History:

- Review of Systems -
- Every three vital signs checked equal one constitutional credit (i.e. pulse, temperature, and blood pressure checked equal one constitutional.)

Coding Tips continued…

- The neurologic examination can be documented by stating that the patient is alert and oriented.
- The psychiatric examination can be documented by describing the patient's mood and affect.

Coding Tips continued…

- The following statement can give credit for the documentation of three body systems:

  "The patient is well nourished, well developed, alert and oriented, in no acute distress."

Coding Tips continued…

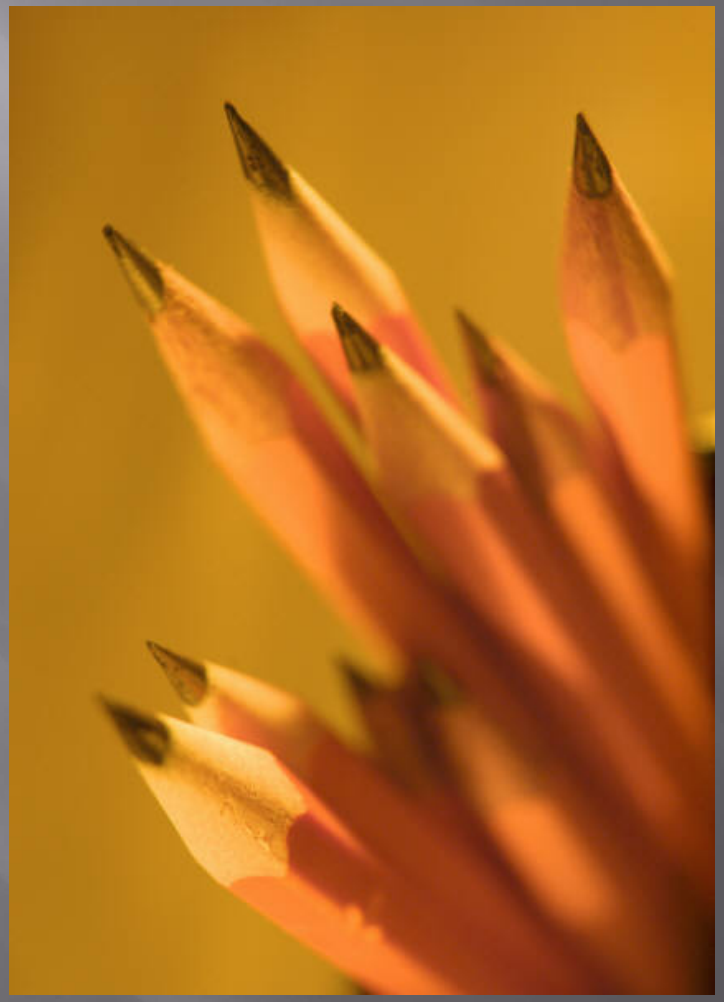
- Medical Decision Making:

- The number of diagnoses listed does not pertain to the HPI, but can be utilized to determine appropriateness of the medical decision making (MDM).

Coding Tips continued…

- CMS now wants providers to document the diagnosis AND what the provider thinks is "probable," "likely," "suspected" or "rule out" along with the key clinical indicators under the MDM area on the chart to support medical necessity, but NOT on the claim forms.

Ready, set, code…



Remember to…Enjoy the Journey!!