ICD-10: Ambulatory Care Impacts
Supporting Staff and Leadership in the Transition
Road Map

1. Background on ICD-10
2. Ambulatory Care Impacts
3. Understanding the Increase in Specificity
4. ICD-10 Transition Planning at The Valley Hospital
On **October 1, 2015**, the Centers for Medicare and Medicaid Services (CMS) has mandated that the U.S. transition from ICD-9 to ICD-10, which will be used for coding, quality, and billing/reimbursement. This transition increased the code volume from 16K in ICD-9 to ~150K in ICD-10.
Significant Changes on the Horizon

This migration from the current ICD-9 standard to the ICD-10 standard will represent one of the greatest changes in health care information in many years.

Joseph C. Nichols, MD
Author of “ICD-10 – A Primer”

Substantial Costs Incurred and Expected to Continue

ICD-10 is expected to be the most costly government-mandated change ever in the healthcare industry.

WEDI
ICD-10 Implementation
White Paper May 5, 2011
A Brief History of the ICD-10 Legislation

The Road to October 1, 2015

- **January 16, 2009**
  Final rule announced requiring all HIPAA-covered entities to implement ICD-10, with October 1, 2013 compliance date

- **February 16, 2012**
  HHS Secretary announces intent to postpone compliance date

- **August 24, 2012**
  HHS announces final rule that delays the compliance date to October 1, 2014

- **March 31, 2014**
  Congress passes H.R. 4302 which focused on a the SGR (‘doc fix’) but delayed ICD-10 implementation to 2015

- **October 1, 2015**
  ICD-10 compliance date

**Why the Delay?**

- **Initial CMS Delay(s):** Hospitals, health systems, and physicians’ efforts to comply with Meaningful Use Stage 2 requirements and overall lack of preparation to be compliant with ICD-10 by October 1, 2013, according to CMS survey

- **Congressional Delay:** Unexpected by many across the industry, likely due to lobbying efforts. Minimal warning or insight provided as to the reasoning for this delay
ICD-9 Deconstructed

History of ICD-9

• World Health Organization (WHO) endorsed ICD-9 codes for use worldwide
• U.S. developed clinical modification (ICD-9-CM) in 1979
• Expanded number of diagnosis codes; developed inpatient procedure coding system

ICD-9 Uses Today

• Calculate Payment: Medicare Severity-Diagnosis Related Groups (MS-DRGs)
• Adjudicate Coverage: diagnosis codes for all settings
• Compile statistics
• Assess quality

Current ICD-9 Users

• ICD-9-CM Diagnoses: used by all types of providers
• ICD-9-CM Procedures: used only by inpatient hospitals
• CPT Codes (Current Procedural Terminology): used for all ambulatory and physician procedure reporting

Why a New System?

• ICD-9 cannot accurately describe the diagnoses and inpatient procedures of care delivered in the 21st century
• Unable to easily track and trend diseases for world-wide comparison in order to assist in the advancing the practice of medicine

Source: The Advisory Board Company research; Health Data Consulting
ICD-9 vs. ICD-10

The main difference between ICD-9-CM and ICD-10-CM/PCS codes, outside of structural changes, is the SPECIFICITY of the code.

ICD-10-CM/PCS codes specify several components not found ICD-9-CM, such as causal agent, type, laterality, approach, episode of care, root operation, etc.

Key ICD-10-CM Documentation Concepts

<table>
<thead>
<tr>
<th>Specific anatomical location</th>
<th>Degree (mild, moderate, severe, or unspecified; total/complete vs. partial/incomplete)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type (primary, secondary, unspecified)</td>
<td>Episode of Care (Initial, Subsequent, Sequelae)</td>
</tr>
<tr>
<td>Acuity (acute, subacute, chronic, acute on chronic, or unspecified)</td>
<td>Laterality (Right, Left, bilateral, or unspecified)</td>
</tr>
</tbody>
</table>

Why so many new codes?

The main difference between ICD-9-CM and ICD-10-CM/PCS codes, outside of structural changes, is the SPECIFICITY of the code.

ICD-10-CM/PCS codes specify several components not found ICD-9-CM, such as causal agent, type, laterality, approach, episode of care, root operation, etc.
The transition to ICD-10-CM/PCS will allow for precise diagnosis and procedure codes, resulting in the improved capture of health care information and more accurate reimbursement.

<table>
<thead>
<tr>
<th>Reflect 21st century medicine:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical terminology</td>
</tr>
<tr>
<td>• New procedures</td>
</tr>
<tr>
<td>• Devices and technology adoption</td>
</tr>
<tr>
<td>• Disease reclassification based on current knowledge of medicine</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improved patient health information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Understand reported condition, and severity and risk in greater detail</td>
</tr>
<tr>
<td>• Categorize conditions and procedures from granularity</td>
</tr>
<tr>
<td>• Patient noncompliance codes help provider accountability for outcomes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improved public health information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emerging diseases</td>
</tr>
<tr>
<td>• Injuries</td>
</tr>
<tr>
<td>• Dangerous settings &amp; products</td>
</tr>
<tr>
<td>• Detect fraud, abuse and waste</td>
</tr>
</tbody>
</table>
Road Map

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Nearly Every Department Will Be Impacted

Source: AAPC.com/icd-10

**Physicians**
- Documentation
- Code training

**Nurses**
- Forms
- Documentation
- Prior authorization

**Lab**
- Documentation
- Reporting
- Authorization

**Managers**
- New policies and procedures
- Vendor and payer contracts
- Budgets
- Training Plan

**Billing**
- Policies and procedures
- Training

**Registration/Scheduling**
- System updates
- Financial Clearance

**Coding**
- Code set
- Clinical knowledge
- Concurrent use

**Additional Sites to Consider**
- Post Acute Care- LTC
- Behavioral Health
- Physician Offices
Where Can We Expect to Lose Momentum?

Key areas that will be impacted by the ICD-10 transition

- **Physician Queries:** ~20% Increase expected due to increased specificity required
- **Physician Productivity:** ~5% Reduction anticipated per note
- **Coder Productivity (Short Term):** ~50% Reduction due to learning curve and physician queries
- **Coder Productivity (Long Term):** ~20% Permanent reduction due to new code structure
- **Denial Risk:** Key areas such as authorizations and medical necessity are impacted
- **Underpayment Risk:** Complete claim processing cannot be analyzed until go-live
- **Workarounds:** Several new and cumbersome workflows to address various nuances
- **Operational Costs:** Additional staff and/or outsourcing to address all of the above
- **Cash Shortage:** >20% Increase in AR Days and DNFB is very possible
Prevent Denials Prior to Patient Service

What is a Denial?
A notification that a portion or all of the patient services will not be reimbursed by the insurer due to incorrect patient information, timeliness of billing, or a determination by the payer that the procedure is not covered based on the plan guidelines.

Common Patient Access Denials:
- **Medical Necessity:** Medicare pays for medical items and services that are deemed "reasonable and necessary" for a variety of purposes. Medicare has a number of policies, including National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) that describe coverage criteria. If services fail to meet medical necessity guidelines, providers must present an Advance Beneficiary Notification (ABN) to the patient prior to rendering the services. The ABN informs the patient the service rendered will not be covered and will be their responsibility. If the provider fails this obligation they cannot be reimbursed by the Medicare program and disallowed to pursue the patient for payment.

- **Authorization:** Similar to Medicare, commercial and state insurances only reimburse procedures they deem medically necessary. Insurances review patient diagnosis codes and medical history to determine whether a procedure will be authorized (or pre-certified).

- **Eligibility:** Hospitals will not receive reimbursement for services rendered if the patient insurance is not active or incorrectly billed as primary verses secondary.
Impact Spans the Acute and Ambulatory Settings

Addressing Documentation and Query Impacts

Potential physician workflow disruption derive from new documentation requirements and increased query volumes that may exist to facilitate code assignment.

Hospital: Coding Challenges

Documentation
• Additional clinical details must be noted.

Queries
• Additional requests from coders attempting to enter procedures and diagnoses into information systems.
• Additional requests from documentation improvement staff.

Challenges in the Physician Practice Area

Coding Challenges Yield Operational and Financial Impacts

**Coding Challenges**
- Paper encounter form becomes a thing of the past
- Code structure, number, detail, rules, sequencing, definitions, and relationships
- Insufficient physician documentation
- Finding the correct codes

**Operational Challenges**

**Financial Challenges**

**What it Affects**
- Practice Management System
- Encounter Form
- Staff Training

Physician documents patient and procedure details

Coder tries to crosswalk codes

Increase in denied claims from payer
Impact on Operational Day to Day Management

ICD-10 Transition Creates Structural Changes that Need to be Made

Impact on Operational Management

- Workflow disruptions
  - Training time
  - Coding productivity
- Updates to electronic health record systems
- Redesign of the encounter form

What it Affects

- Patient Flow in the Office
- Coding Efficiency
- Public Health Reporting
- Clinical and Quality Reporting
- Encounter Forms
- Practice Management System
- EMR

The Traditional Encounter Form Can’t be Populated with ICD-10 Codes

Create and Implement Strategies Early to Prevent Workflow Crisis
How Financial Coverage is Affected

ICD-10 Will Impact Physician Practice Revenue

Coding Challenges  Operational Challenges  Financial Challenges

Impact on Financial Coverage
- Harder to track performance based achievement goals
- 10-20% estimated increase in denials
  - Processing rules
  - Remediation of medical policies
  - Crosswalk complications
- Differences in authorization and referral triggers
- Increased scrutiny of documentation to prevent fraud and abuse

What it Affects
- Conversations with Vendors
- Conversations with Payers
- Budget for New or Updated Technology
- Revenue from Lost Productivity and Increase in Denials

Physicians Discuss ICD-10 with Vendors
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Beyond a Change in Code Volume

Additional Detail Found Within ICD-10-CM Codes

- Differences between ICD-9 and ICD-10-CM Code Standards

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes (Vol. 1 &amp; 2)</th>
<th>ICD-10-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 5 characters all numeric (except for the 1\textsuperscript{st} character for “E” and “V” codes)</td>
<td>Up to 7 characters all of which could be alpha or numeric characters</td>
</tr>
<tr>
<td>Limited inclusion of co-morbidities, complications, severity, manifestation, risk, sequel, and other disease related parameters</td>
<td>Includes many of these parameters within codes</td>
</tr>
<tr>
<td>Does not distinguish laterality (left vs. right vs. bilateral)</td>
<td>Usually includes laterality where appropriate</td>
</tr>
<tr>
<td>Does not define initial and subsequent encounters</td>
<td>Includes these concepts</td>
</tr>
<tr>
<td>Expansion ability is limited</td>
<td>Alphanumeric support and place holder characters provide significant ability to expand the codes sets without a significant structural change</td>
</tr>
<tr>
<td>Consistency of terms and definition has been a challenge</td>
<td>Consistency for terms and concepts has been improved</td>
</tr>
<tr>
<td>Combination codes are limited</td>
<td>Combination codes are frequent, with multiple distinct medical concepts per code</td>
</tr>
</tbody>
</table>

Concepts Drive Changes in Documentation

Key Considerations for Post Acute Care in ICD-10-CM

Laterality

- Type of Vessel
- Complication
- Onset
- Type of Infection
- Acuity
- Inflammation Site
- Infection Site
- Causal Agent
## Transition Represents Major Changes in Coding

### ICD-9
- Code structure is 3-5 characters, characters 2 through 5 always numeric
- Code data (despite known limitations) is the basis for patient care improvement, quality reviews, medical research and reimbursement

### ICD-10
- Code structure is 3-7 alphanumeric characters
- Specific diagnosis and treatment information better supports quality and patient safety measurement, the evaluation of medical processes and outcomes, and reimbursement for services rendered
- Precise codes to differentiate body parts, surgical approaches, and devices used

### ICD-9-CM Pressure Ulcer Codes
- 9 location codes (707.00 – 707.09)
- Show broad location, but not depth (stage)

### ICD-10-CM Pressure Ulcer Codes
- 125 codes
- Show more specific location as well as depth, including
  - L89.131 – Pressure ulcer of right lower back, stage I
  - L89.132 – Pressure ulcer of right lower back, stage II
  - L89.133 – Pressure ulcer of right lower back, stage III
  - L89.134 – Pressure ulcer of right lower back, stage IV
  - *and many more*..
Introduction to ICD-10 Diagnosis Structure

- Category
- Sub-categories
  - (Etiology, Anatomic Site, Severity, Laterality, Complication)
- Extension
  - (3-16 options depending on category)
Diagnosis Example: Coronary Artery Disease

Atherosclerosis of nonautologous biological coronary artery bypass graft(s) with unstable angina pectoris

Chronic Ischemic Heart Disease

Vessel Type
- Native coronary artery
- Autologous vein graft
- Nonautologous biological graft

Type of Angina
- Unstable Angina pectoris
- Angina pectoris with documented spasm
- Other forms of angina pectoris
- Other Graft
- Unspecific
Diagnosis Example: Heart Failure

**Acute systolic heart failure**

- **Heart Failure**: 1 5 0
- **Type of Heart Failure**: 2
- **Severity**: 1

- **Heart Failure**
  - **Acute**
  - **Chronic**
  - **Acute on Chronic**
  - **Unspecific**
  - **Combined Systolic + Diastolic**
  - **Diastolic**
  - **Unspecific**
A Comparison of ICD-9 and ICD-10

Diagnosis Code Clinical Example

A provider sees a patient in a subsequent encounter for a non-union of an open fracture of the right distal radius with intra-articular extension and a minimal opening with minimal tissue damage.

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81352</td>
<td>Other Open Fracture of Distal End of Radius (Alone)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S52571M</td>
<td>Other intra-articular fracture of lower end of right radius, subsequent encounter for open fracture type I or II with nonunion</td>
</tr>
</tbody>
</table>

For all codes related to fractures of the radius:
- Volume of ICD-9 codes = 33
- Volume of ICD-10 codes = 1,818
Nothing Remains the Same
No Longer the Same Old Favorites to Select From

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.02</td>
<td>E11.65</td>
</tr>
<tr>
<td>Diabetes mellitus without mention of complication, type II or unspecified type, uncontrolled</td>
<td>Type 2 diabetes mellitus with hyperglycemia</td>
</tr>
<tr>
<td>250.43</td>
<td>E10.21</td>
</tr>
<tr>
<td>Diabetes with renal manifestations, type I [juvenile type], uncontrolled</td>
<td>Type I diabetes mellitus with diabetic nephropathy AND</td>
</tr>
<tr>
<td></td>
<td>E10.65</td>
</tr>
<tr>
<td></td>
<td>Type I diabetes mellitus with hyperglycemia</td>
</tr>
</tbody>
</table>

**Well… Not Exactly…**

Not much will change. I use 250.0_ for diabetes in my office now. In the future, I will still use 250.0_. I will just need to add more information in the record to support it.

VPMA
300+ bed facility

**Required ICD-10 Concepts:** Controlled vs. Uncontrolled, Type, Clinical Details of Disease Manifestation, etc.
# 250.00 - Diabetes mellitus without mention of complication, type II or unspecified type, not stated as uncontrolled

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Example of ICD-10-CM Code</th>
</tr>
</thead>
</table>
| 250.00 Diabetes mellitus without mention of complication, **type II or unspecified type**, not stated as uncontrolled | - **E119** Type 2 diabetes mellitus without complications  
- **E139** Other specified diabetes mellitus without complication |

## ICD-10-CM Key Terminology Change

- If left unspecified, diabetes will default to the DM Type 2
- It is no longer required to specify ‘controlled’ or ‘uncontrolled’ diabetes
Diabetes and Manifestations

Type II Diabetes Mellitus with diabetic neuropathy, unspecified

- Mononeuropathy
- Polyneuropathy
- Autonomic (poly)neuropathy
- Neuropathy Unspecified
- Amyotrophy
- Other Diabetic Neurological Complications
Link Diabetes to Manifestations & Complications

Providing sufficient documentation to link diabetes to manifestations and/or complications, when appropriate, can significantly increase the severity of illness (SOI) of the patient.

1) The term “with”:
   • Diabetes “with”:
     • Hypoglycemia
     • Hyperglycemia
     • Hyperosmolarity
     • Ketoacidosis
     • Coma/nonketotic hyperglycemic-hyperosmolar coma

   Two Ways to Capture Documentation:

2) The term “Diabetic”:
   • Diabetic nephropathy
   • Diabetic chronic kidney disease stage 4
   • Diabetic gastroparesis
   • Diabetic neuropathy (mono/poly/autonomic)

Example: “Type 2 DM with hypoglycemia without coma with diabetic gastroparesis”

Key Terminology Changes:

Note:
   • The term “uncontrolled” or “controlled” does not exist in ICD-10-CM.
   • When diabetes is documented as “inadequately controlled, poorly controlled, or out of control” it will be coded to diabetes by type with the complication of hyperglycemia.
### 414.00 - Coronary atherosclerosis of unspecified type of vessel, native or graft

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Example of ICD-10-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>414.00 Coronary atherosclerosis of unspecified type of vessel, native or graft</td>
<td>I25.10 Atherosclerotic heart disease of native coronary artery without angina pectoris</td>
</tr>
<tr>
<td>1:1 code conversion in ICD-10-CM</td>
<td></td>
</tr>
</tbody>
</table>

**Documentation Concepts**

<table>
<thead>
<tr>
<th>Type of Vessel</th>
<th>What You Need to Specify</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Of unspecified type of vessel, native or graft</td>
<td></td>
</tr>
<tr>
<td>• Of native coronary artery</td>
<td></td>
</tr>
<tr>
<td>• Of autologous vein bypass graft</td>
<td></td>
</tr>
<tr>
<td>• Of nonautologous biological bypass graft</td>
<td></td>
</tr>
<tr>
<td>• Of artery bypass graft</td>
<td></td>
</tr>
<tr>
<td>• Of unspecified type of bypass graft</td>
<td></td>
</tr>
<tr>
<td>• Of native coronary artery of transplanted heart</td>
<td></td>
</tr>
<tr>
<td>• Of bypass graft (artery) (vein) of transplanted heart</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Symptoms</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• With unstable angina pectoris</td>
<td></td>
</tr>
<tr>
<td>• With angina pectoris and spasm</td>
<td></td>
</tr>
<tr>
<td>• With other forms of angina pectoris</td>
<td></td>
</tr>
<tr>
<td>• With unspecific angina pectoris</td>
<td></td>
</tr>
</tbody>
</table>
# 427.31 - Atrial Fibrillation

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Example of ICD-10-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>427.31 Atrial fibrillation</td>
<td>\begin{itemize} \item I48.0 Paroxysmal \item I48.1 Persistent \item I48.2 Chronic (Permanent) \item I48.91 Unspecified \end{itemize}</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Documentation Concepts</th>
<th>What You Need to Specify</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Paroxysmal</strong></td>
<td>These episodes end spontaneously within 7 days and most episodes last &lt; 24 hours</td>
</tr>
<tr>
<td><strong>Persistent</strong></td>
<td>These episodes last &gt; 7 days and may require electrical or pharmacologic intervention</td>
</tr>
<tr>
<td><strong>Permanent (chronic)</strong></td>
<td>Lasts &gt; than 1 year, regardless of whether cardioversion has been attempted and has failed or has never been attempted</td>
</tr>
<tr>
<td><strong>Unspecified</strong></td>
<td>No documentation to the specificity of the Afib → lower SOI</td>
</tr>
</tbody>
</table>

*Persistent AFIB is a driver of severity of illness*
Chronic Diastolic (Congestive) Heart Failure

Heart Failure

Type

Acuity

Acute

Acute on Chronic

Chronic

Unspecified
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A Large Number of Variables Pose Challenges for Transition Planning

- Denials, Non-Payments, Delays
- Coding Productivity and Rework
- Technology
- Quality Metrics
- Training and Education
- Operational Changes
- Vendors and Payers

Transition to ICD-10
Organizational Chart for ICD-10 at The Valley Hospital

Executive Sponsor
Peter Diestel

ICD-10 Steering Committee
Michelle Fuchs, Josette Portalatin, Bill Klutkowski, John McConnell, Ken Parker & Mike Burke

HIM
- Team Leader
- Team Members

Revenue Cycle
- Team Leader
- Team Members

IT
- Team Leader
- Team Members

CDI/Physician Engagement
- Team Leader
- Team Members

Quality & Reports
- Team Leader
- Team Members

Communications
- Team Leader
- Team Members
What Is The Valley Hospital Doing Today?

Key Initiatives Will Support the Transition to ICD-10

Initiatives Supporting ICD-10 at The Valley Hospital

- Formalized organizational structure
- Developed multi-year project plan with supporting time line, goals, and budget
- Ongoing partnership with The Advisory Board to ensure that the strategy is sound, stays current, and deadlines are met
- Working on targeted Revenue Cycle initiatives relating to patient access accuracy, denials management, A/R reduction strategies, cash collection, and coding workflow
- Investing significantly in coder recruitment, ICD-10 education and training, and retention activities
- Developing targeted, specialty-specific education and training for attending and consulting physicians
- Commitment to help ease transition burden by sharing information and resources with affiliated physicians
The Engagement Team

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Paul Gallo
Associate Director
GalloP@advisory.com

Please do not hesitate to contact your team with any questions or comments.