Beyond ICD-10 Implementation

Mid Michigan Medical Billers Association
March 16, 2016

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*NOTE: The information in this document is not intended to impart legal advice. This overview is intended as an educational tool only and should not be relied upon as a substitute for professional or specialized advice.

Agenda

- Fun Facts about ICD-10 implementation at BCBSM
- Issues post implementation
  - Review of claims
  - Coding of encounters
  - Additions to benefit tables
- Suggestions for topics for provider fairs and additional ICD-10 articles
- Contact information

Ten Fun Facts about ICD-10 implementation at BCBSM

<table>
<thead>
<tr>
<th>Count</th>
<th>ICD-10 Facts</th>
</tr>
</thead>
<tbody>
<tr>
<td>61,000,000</td>
<td>Clearing house transactions tested with the top 35 clearing houses</td>
</tr>
<tr>
<td>2,000,000</td>
<td>Lines of NASCO benefit code modified for ICD-10</td>
</tr>
<tr>
<td>589,200</td>
<td>Hours of labor engaged to complete ICD-10 remediation (265 person years)</td>
</tr>
<tr>
<td>197,000</td>
<td>Claims tested for payment neutrality using DRGs</td>
</tr>
<tr>
<td>17,100</td>
<td>Providers attending BCBSM ICD-10 webinars, presentations and training sessions</td>
</tr>
<tr>
<td>4,914</td>
<td>NASCO system test cases</td>
</tr>
<tr>
<td>2,555</td>
<td>The number of days the project lasted (7 years)</td>
</tr>
<tr>
<td>696</td>
<td>ICD-10 project tasks in the 2015 project plan</td>
</tr>
<tr>
<td>98</td>
<td>Providers and facilities completed end to end testing</td>
</tr>
<tr>
<td>87</td>
<td>ICD-10 articles were published in the Record, Physician and Hospital newsletters</td>
</tr>
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Post Implementation Activities: Claims Review

- Reviewed claims which paid and rejected to ensure they processed correctly.
- Focus on rejections with large number of claims
  - Did we miss including codes on the benefit tables?
  - Accurate use of codes by the providers?
  - Use of the CMS GEMs for code selection
- Monitoring use of unspecified codes

Post Implementation Activities: Claims Review Rejection Reasons

- Did we miss including codes on the benefit tables
  - Was coding different than our expectations?
  - We missed some 7th characters and had to add them for chiropractors and PT/OT/speech benefit tables
- Understanding the place holder and 7th character usage
  - Communication from some offices thought they had to add Xs to every code to make all diagnosis codes 7 characters long.
  - CMS and AHA hosted webinars to provide additional guidance on 7th characters and to differentiate between initial and subsequent visits. Focus is on treatment rendered rather than just seeing a new physician.

Post Implementation Activities: Physician Office Activities

- Monitoring use of unspecified codes
  - EHRs not giving the choice of right, left or bilateral
    - Follow up with record review to identify a more specific
    - May make a difference for payment of benefits for the member
- Use of Benefit Explainer to verify benefits for a member
  - Group may not pay for procedure (i.e. vaccines)
    - May have a diagnosis or location restriction
- Understanding the place holder and 7th character usage
- Following the Official Coding Guidelines
**Post Implementation Activities: Claims Review 7th Character Usage**

- **Initial encounter:** As long as patient is receiving active treatment for the condition
  - Examples: surgical treatment, emergency department encounter and evaluation and continuing active treatment by the same or a different physician

- **Subsequent encounter:** After patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.
  - Examples: cast change or removal, an x-ray to check healing status of fracture, removal of external or internal fixation device, medication adjustment, other aftercare and follow-up visits following treatment of the injury or condition.
  - For aftercare of injury, assign acute injury code with the 7th character for subsequent encounter.

- **Sequela:** Complications or conditions that arise as a direct result of condition (scar formation after a burn).

**Post Implementation Activities: Claims Review Official Coding Guidelines**

- CMS required the Medicare Advantage plans to implement edits related to the coding guidelines, specifically Excludes1 Notes

- **Excludes1 definition:** (laymen's terms) You can’t code these conditions together, because these conditions cannot occur together.
  - Examples:
    - Diabetes 1 and 2
    - Congenital and acquired hydrocephalus

- When codes with an Excludes1 note was present with the other code specified as being excluded the claims were rejected.

- As part of our review we found errors in the logic and the edit was turned off at that time, until corrections could be made.

**Just because it maps, doesn't mean it's right...**

- ICD-9 code 990, Effects of radiation, unspecified
  - Complication of
    - Phototherapy
    - Radiation therapy
    - Radiation sickness
  - Excludes specified adverse effects of radiation (such as a burn)

- ICD-10 code T66XXXA(or D or S), Radiation sickness, unspecified (forward and backward mapping)
  - Excludes1 specified adverse effects of radiation (such as a burn...T20-T31, need location and degree)

- Is this really what the patient had, or did they have an adverse effect?
Z Codes: Factors Influencing Health Status and Contact with Health Services

- Encounter for Immunization, Z23
  - Use with both the procedure codes for the immunization and the administration of the immunization
  - We frequently saw submission of code Z41.8, Encounter for other procedures for purposes other than remediating health state used for the administration procedure code.

- Person with feared complaint in whom no diagnosis is made, Z71.1
  - Used mainly for patients having lab work done. Labs will report this code if they aren’t given a diagnosis code.
  - Provide the reason for the test, including a preventive exam

- BMI, Z68 codes
  - Report as a secondary diagnosis

Z Codes: Factors Influencing Health Status and Contact with Health Services

- Z3A codes for Weeks of Gestation
  - Use only as a secondary diagnosis code
  - Code first the complications of pregnancy, childbirth and the puerperium
  - Codes were being used as the first listed diagnosis on obstetric claims as the reason for the ultrasound

- Z51.11 Encounter for antineoplastic chemotherapy
  - Should be listed as first (principal) diagnosis
  - Medicare was requiring Medicare Advantage claims with Z51.11 listed as secondary to be rejected.
  - Concerns voiced by Michigan Society of Hematology and Oncology regarding specific drugs which have to be submitted with specific diagnosis codes.

Implementation Success: 4 Lessons from CMS and how BCBSM Succeeded

- Lesson 1: Be Customer Focused CMS
  - CMS: start from the needs of the people who will live with the implementation; listening, learning, understanding the resource and technical assistance needs, concerns over payment/cash flow
  - Response was not the “Road to 10” aimed specifically at smaller physician practices providing info on clinical documentation, clinical scenarios and other specialty specific resources
  - BCBSM: our primary premise was to process claims the same way in ICD-10 as we did in ICD-9, we also listened and learned from the provider community
  - We created the testing tool for both hospitals and physician offices
  - We spoke at approximately 150 meetings between 2014 and 2015, provided webinars on a monthly basis
Implementation Success: 4 Lessons from CMS and how BCBSM Succeeded

Lesson 2: Be Highly Collaborative

- CMS: worked in partnerships with AMA, AHA, AHIMA, state medical societies, physicians and other clinicians, billing vendors, DME suppliers and other stakeholders.
  - Response was the “Road to 10” aimed specifically at smaller physician practices providing info on clinical documentation, clinical scenarios and other specialty specific resources.
- BCBSM: we worked in partnerships with other clearinghouses, vendors, state and national associations as well as our competitors.
  - We created the testing tool for both hospitals and physician offices.
  - We spoke at approximately 150 meetings between 2014 and 2015, provided webinars on a monthly basis.
  - We formed a consortium with our competition, 5 plans speaking with one voice.
  - Provided resources to the community in a variety of ways.

Lesson 3: Be Responsive and Accountable

- CMS: anticipate the challenges, make them visible and be accountable for solving them.
  - Challenge was for every system that connected to Medicare.
  - Response was to create Ombudsman office with a 3 business day response time. In the first month they received 1000 inquiries and met the 3 day turnaround on each one.
- BCBSM: we had the same goals.
  - We performed months of testing on millions of claims to anticipate any issues we might have created.
  - Contact to us was in the way of provider outreach staff, provider inquiry, and ICD-10 inquiry mailbox.
  - Provided resources to the community in a variety of ways.
  - During the first quarter we had daily phone calls for our command and control center to identify and work to resolve issues identified.

Lesson 4: Be Driven by Metrics

- CMS: Daily spreadsheets and scorecards keep complex implementations on track.
  - Receiving fewer claims?
  - Generating more denials?
  - Particular state having trouble with processing Medicaid claims.
- BCBSM: we had the daily (early on twice daily) Command and Control meetings/calls to identify issues, determine solutions and implement those solutions. Also to determine, were we:
  - We monitored increased paper claim submission, EDI rejections.
  - Reviewed claims paid and rejected to determine if paid correctly and if rejected, root cause.
  - Monitored percentage of calls to PIO, ICD-10 generated less than 1% of calls during 4Q15.
New Codes Fiscal year 2017

- New PCS Codes
  - 71,974 codes in FY 2016
  - 75,625 for FY 2017
    - 3657 additions
    - 754 revisions
      - 175 revisions to long and short titles
      - 579 revisions to long title only
    - 247 revisions to short title only
  - ICD-10 Coordination and Maintenance Committee March 9
    - 15 Topics were discussed
    - Agenda can be reviewed at link below
    - Link to file
    - Downloads box
      - FY2017 New Revised ICD-10-PCS Codes

- New CM Codes
  - 69,823 codes in FY 2016
  - ??? for FY 2017
    - 1900 additions
    - 313 deletions
    - 351 revisions
      - ??? revisions to both long and short titles
      - ??? revisions to long title only
      - ??? revisions to short title only
  - ICD-10 Coordination and Maintenance Committee March 10
    - 25 Topics discussed most were for FY 2018 implementation date
    - Link to file
      - Not available as of 3/15/16, but keep checking the cdc.gov website. The file is supposed to be released this week

General Equivalence Mappings

CMS committed that GEMs would be refreshed and available for 3 years, so they will be available through October 1, 2018.
Resources

- The BCBSM website for ICD-10 information has moved. Here is the new link.

- CMS has created a new Next Steps Toolkit (5 pages)

  - Topics include:
    - Assessing your progress – Key Performance Indicators
    - Addressing your findings – Troubleshooting
    - Maintaining your progress – Keeping your systems and coding resources up to date