



PatagoniaHealth



ICD-10 Readiness for Public Health

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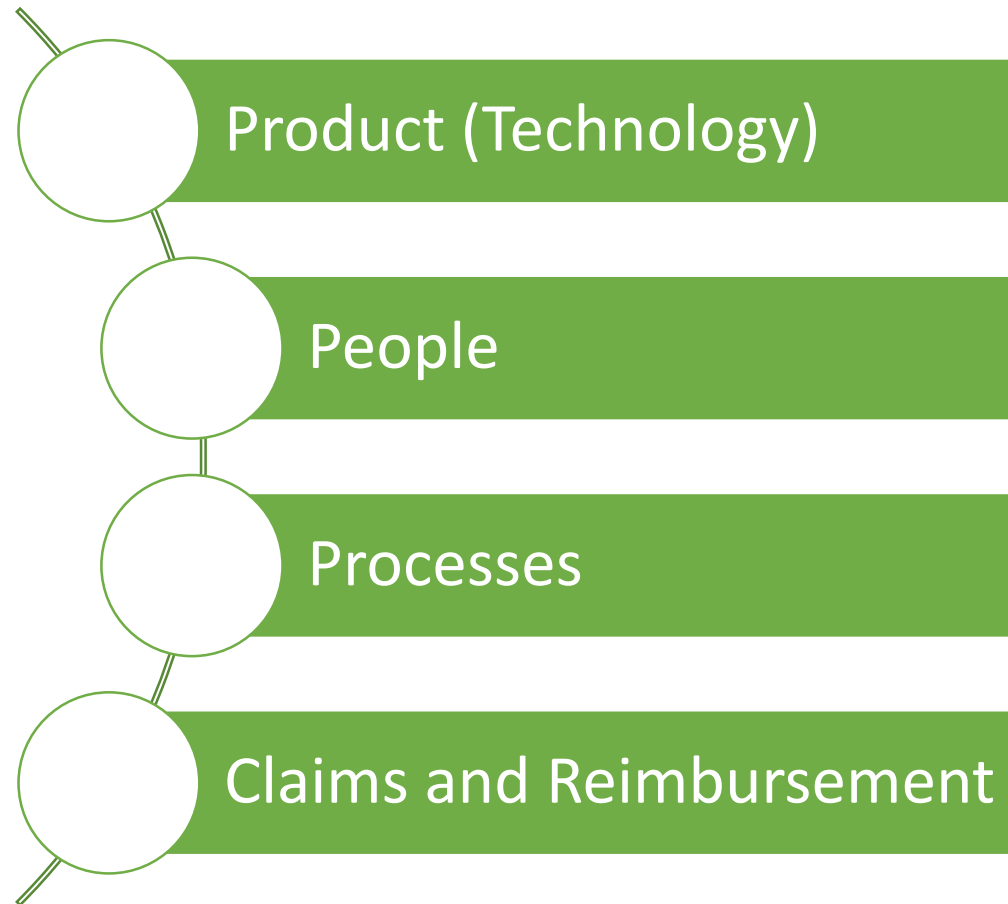
- ▲ ICD-10 Overview and Impacts
- ▲ ICD-9 vs. ICD-10 Differences
- ▲ ICD-10 Transition Tasks
 - Planning and Staffing
 - Internal Processes
 - Remediation Work
- ▲ Software System Features
- ▲ Payer Testing
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- ▲ Cheat Sheets
- ▲ Working Denials
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ICD-10 Transition Overview

-  ICD-10 is not optional
-  Compliance can be expensive
-  Provider and Administration staff engagement together is required
-  Software vendor participation is key









ICD-10 Impacts



- ▲ There are two books for ICD-10 CM
 - ICD-10 CM - Diagnosis coding system, format similar to ICD-9 CM
 - ICD-10 PCS - Procedure classification system, ONLY for inpatient hospital settings
 - Already being used around the world. The first being used in 1995
- ▲ ICD-9 CM: Doesn't provide the necessary detail of the patients' medical condition
 - 3-5 digits
 - First digit is alpha E, V or numeric
 - Digits 2-5 are numeric
- ▲ ICD-10 CM: Incorporates much greater specificity to diagnosing patients
 - 3-7 digits
 - Digit 1 is always alpha
 - Digits 2 and 3 are numeric
 - Digits 4-7 are alpha or numeric (alpha digits are not case sensitive)

ICD-10 Transition Tasks

-  Planning and staffing
-  Review internal processes
-  Software testing
-  Remediation work
-  Education
-  Go-Live Preparation

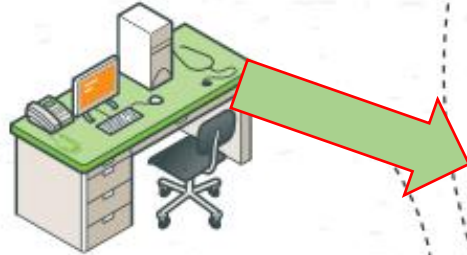
Physicians

Documentation:

The need for specificity dramatically increases by requiring laterality, stages of healing, weeks in pregnancy, episodes of care, and much more.

Code Training:

Codes increase from 17,000 to 140,000. Physicians must be trained.



Clinical Area

Patient Coverage:

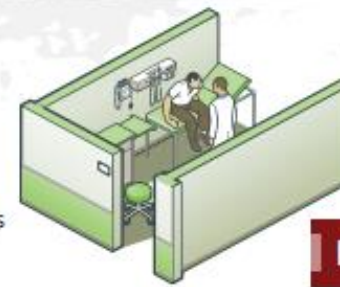
Health plan policies, payment limitations, and new ABN forms are likely.

Superbills:

Revisions required and paper superbills may be impossible.

ABNs:

Health plans will revise all policies linked to LCDs or NCDs, etc., ABN forms must be reformatted and patients will require education.



Managers

New Policies and Procedures:

Any policy or procedure associated with a diagnosis code, disease management, tracking, or PQRI must be revised.

Vendor and Payer Contracts:

All contracts must be evaluated and updated.



Budgets:

Changes to software, training, new contracts, new Paperwork will have to be paid for.

Training Plan:

Everyone in the practice will need training on the changes.

Coding

Code Set:

Codes will increase from 17,000 to 140,000. As a result, code books and styles will completely change.

Clinical Knowledge:

More detailed knowledge of anatomy and medical terminology will be required with increased specificity and more codes.

Concurrent Use:

Coders may need to use ICD-9-CM and ICD-10-CM concurrently for a period of time until all claims are resolved.



Nurse

Forms:

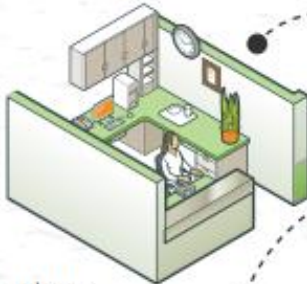
Every order must be revised or recreated.

Documentation:

Must use increased specificity

Prior Authorizations:

Policies may change, requiring training and updates.



Billing

Policies and Procedures:

All payer reimbursement policies may be revised.

Training:

Billing department must be trained on new policies and procedures and the ICD-10-CM code set.



Front Desk

HIPAA:

Privacy policies must be revised and patients will need to sign the new forms.

Systems:

Updates to systems are likely required and may impact patient encounters



Lab

Documentation:

Must use increased specificity

Reporting:

Health plans will have new requirements for the ordering and reporting of services.



Areas in your organization ICD-10 will impact

- Identify a ICD-10 CM transition committee or project leader
 - Identify every single place in your organization where a Diagnoses is used
 - Communicate tasks and timelines to staff members

Internal Processes where Dx is used








- ▲ Scheduling visits or procedure visits based on Diagnosis codes
- ▲ Clinical workflow
 - Patient History
 - Update Assessments and Diagnosis
 - Lab Orders Entry
 - Clinical Templates/Forms
- ▲ Service Authorizations
- ▲ Encounter /Super Bill and claim creation
 - Paper Super Bill
 - Paper claim CMS 1500 forms
- ▲ Frequently Used Reports
 - Program Based State and Federal Reports







- ▲ Scheduling visits or procedure visits
 - Cheat sheets for front office with ICD-10 CM codes
- ▲ Clinical workflow
 - Cheat sheets with cross walks of commonly used diagnosis per program
 - Check with software vendor about existing clinical data
 - Update Lab Orders forms with ICD-10 CM codes
 - Update Clinical Templates/Forms to have increased specificity
- ▲ Encounter /Super Bill and claim creation
 - Update Paper Super Bill
 - Update paper claim CMS 1500 forms to “02/12” version

- ▲ Frequently Used Reports
- ▲ Update canned reports with ICD-10 CM codes
- ▲ Billing needs to review any updated Clinical Coverage Policy, and Local Coverage Determinations, and payer manuals

Software System Features

-  Date of service limitations
-  Dual coding error checks in clinical notes
-  Dual coding error checks in claim creation
-  Coding cross walk
-  Mapping of existing clinical data

Payer Testing

-  Check with clearinghouse and software vendor
-  Check with payer for testing cycles
-  Volunteer to participate in payer testing
-  CMS Medicare testing cycles open since March 2015
-  Check for State Medicaid and MCO testing cycles
-  Not all states' Medicaid and Medicare carriers are ready for testing.

Clinical

- All services will be coded with ICD-10 CM diagnosis on 10/1/2015.
- System will check for dual coding in a clinical visit note
- Existing Patient History, Problem List in patient record will be automatically cross walked to ICD-10 CM format
- Services before 10/1/2015 will be coded in ICD-9 CM diagnosis

Claim creation and reimbursement

- All claims with Date of Service after 10/1/2015 will be in ICD-10 CM
- System will check for dual coding during claim creation
- System will check for coding system based on Date of Service
- User can switch between ICD-9 and ICD-10 CM during claim creation
- GEMS mapping and look up readily available in the system

Patagonia Health Payer Testing Status *PatagoniaHealth*

Patagonia Health

- Successfully tested with State MCO systems in December 2014
- Successfully tested with CMS Medicare testing in few states in May 2015
- Currently testing with State Medicaid systems in June 2015

 Not all states' Medicaid and Medicare carriers are ready for testing.

Program Specific ICD-10 Cheat Sheets PatagoniaHealth

Child Health

ICD 9 code	Description	ICD 10	Description
V20.2	Routine child health exam	Z00.129	Encounter for routine child health examination without abnormal findings
V70.3	Med exam NEC-admin	Z02.89	Encounter for other administrative examinations
V72.2	Dental examination (dental varnishing)	Z01.20	Encounter for dental examination and cleaning without abnormal findings

Family Planning

ICD 9 code	Description	ICD 10	Description
V25.09	Encounter for other general counseling and advice on contraception	Z30.09	Encounter for other general counseling and advice on contraception
V25.49	Other contraceptive method	Z30.49	Encounter for surveillance of other contraceptives
V25.41	Contraceptive pill	Z30.41	Encounter for surveillance of contraceptive pills
V25.11	Insertion of intrauterine contraceptive device	Z30.430	Insertion of intrauterine contraceptive device
V25.40	Contraceptive surveillance, unspecified	Z30.40	Encounter for surveillance of contraceptives, unspecified

Immunization

ICD 9 code	Description	ICD 10	Description
Z23 replaces all ICD9 immunization diagnosis		Z23	Encounter for immunization

Program Specific ICD-10 Cheat Sheets PatagoniaHealth

Tuberculosis

ICD 9 code	Description	ICD 10	Description
V74.1	Screening-pulmonary TB	Z11.1	Encounter for screening for respiratory tuberculosis
795.51	Nonspecific reaction to tuberculin skin test without active tuberculosis	R76.11	Nonspecific reaction to tuberculin skin test without active tuberculosis
Ø12.8Ø	Respiratory TB NEC-unspecified	A15.8	Other respiratory tuberculosis

Sexually Transmitted Diseases

ICD 9 code	Description	ICD 10	Description
V73.89	Special screening for other specified viral diseases	Z11.59	Encounter for screening for other viral diseases
V74.5	Screen for venereal disease	Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
Ø79.98	Chlamydial infection NOS	A74.9	Chlamydial infection NOS

Maternal Health (OB/GYN)

ICD 9 code	Description	ICD 10	Description
		Z3A.00	Weeks of gestation of pregnancy not specified
		Z3A.01	Less than 8 weeks gestation of pregnancy
		Z33.1	Pregnant state, incidental
		Z34.00	Normal first pregnancy, unspecified trimester
		O24.419	Gestational diabetes mellitus, unspecified control
		O09.90	High risk pregnancy, unspecified , unspecified trimester

Program Specific ICD-10 Cheat Sheets *PatagoniaHealth*

Available cheat sheets on our web:

- [Tuberculosis Codes](#)
- [Sexually Transmitted Disease STD Codes](#)
- [Maternal Health Codes](#)
- [Family Planning Codes](#)
- [Child Health Codes](#)
- [Behavioral Health Codes](#)
- [Generic Codes](#)

Patagonia Health Working Denials

- Claims denied for payer not currently accepting ICD-10 CM
 - Change ICD Indicator Dropdown to 9

21. Diagnosis or Nature of Illness or Injury (Relate 1-12/A-L to service line below (24E)): ICD Ind. 9

1(A). V20.2	2(B).	3(C).	4(D).
5(E).	6(F).	7(G).	8(H).
9(I).	10(J).	11(K).	12(L).

- Click the magnifying glass next to do a ICD-9 or ICD-10 CM code lookup

ICD9 Code Lookup

ICD-9 ICD-10

Code: V20.2 Description:

ICD-9 Code	Description
<input checked="" type="radio"/> V20.2	Routine infant or child health check

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Patagonia Health Billing Reports



- ▲ Use Diagnosis Code Version
 - All will run all diagnosis versions
 - 9 will only show ICD-9 CM codes
 - 0 will only show ICD-10 CM codes

▲ Billing Reports will default to diagnosis used on the claim

Search Claim Detail Report	
Rendering Provider	All ▼
Referring Provider	All ▼
Location	All ▼
Insurance Type	All ▼
Payer ID	IN ▼ <input type="text"/> 🔍
Payer Name	<input type="text"/> 🔍
Billing Provider NPI	<input type="text"/> 🔍
Claim Received Date	From <input type="text"/> 🔍 To <input type="text"/> 🔍
Claim Service Date	From <input type="text"/> 🔍 To <input type="text"/> 🔍
Claim Submitted Date	From <input type="text"/> 🔍 To <input type="text"/> 🔍
Claim Amount Range	From <input type="text"/> To <input type="text"/>
Diagnosis Code Version	All ▼
Diagnosis Code	All <input type="text"/> 🔍
Procedure Code	9 <input type="text"/> 🔍
	0 <input type="text"/> 🔍

Clinical Documentation Impacts

-  Onset of Care
-  Anatomical site specificity
-  Laterality
-  Disease severity
-  Etiology and Manifestation
-  Complications
-  Combination Codes
-  Non-specific/unspecified

- ▲ Only one Immunization code: Z23
- ▲ Type of vaccine identified by the CPT or HCPCS code
- ▲ Vaccine specific documentation still required
- ▲ Report only code Z23 for an encounter involving immunization regardless of the type or number of vaccines

Influenza and Pneumonia coding simplified:

- Two ICD-9 codes
 - V04.81 - influenza vaccine alone
 - V06.6 if you provide both the influenza vaccine and the pneumonia vaccine on the same date
- One ICD-10 CM code
 - Z23 - regardless of how many or what types of vaccines are administered

If a vaccination is not carried out, note the reason such as:

- Compromised condition of patient
- Patient refusal
- Parent/caregiver refusal




Increased Specificity

- ICD-10 will improve the quality of data collection for well child exams, early screening, and the detection of childhood illnesses.
- When documenting well child exams and screenings include the following:
 - Child's age: in days, months or years
 - Exam type: e.g. well child exam, hearing screens, sports physicals, school physical, etc.
 - Findings: normal vs abnormal findings, as the codes vary depending on results










Coding

- ICD-10 Code Examples:
 - Z00.110 Newborn check under 8 days old
 - Z00.111 Newborn check 8 to 28 days old
 - Z00.121 Encounter for routine child health examination with abnormal findings
 - Z00.129 Encounter for routine child health examination without abnormal findings

Gynecological Documentation

-  Documentation of gynecological conditions is relatively unchanged
-  Vaginitis is further classified as either vaginitis or vulvitis and includes the specification of acute or sub-acute or chronic
-  Delineation of a high risk screening mammogram is not available

Pregnancy / Prenatal Documentation

-  In ICD-10 CM, antepartum encounters are classified by the trimester at the time of the encounter.
-  Hence documentation of trimester is required.
-  Trimester determination is calculated from first day of last menstrual period, and is documented in weeks.
-  Code from category Z3A.- , Weeks of gestation, should be reported to identify week of pregnancy.
 -  Z3A.00 Weeks of gestation of pregnancy not specified
 -  Z3A.01 Less than 8 weeks of gestation of pregnancy
 -  Z3A.08 8 weeks of gestation of pregnancy
 -  Z3A.09 9 weeks of gestation of pregnancy
-  ICD-10 allows for the description of “pregnancy”, “childbirth” and “puerperium” as distinct concepts from “trimester.”

Pregnancy / Prenatal Documentation

- ▶ OB codes in ICD-10 CM start with the letter “O” and not with the number “0”
 - O99.351 Diseases of the nervous system complicating pregnancy, first trimester
 - O99.352 Diseases of the nervous system complicating the pregnancy, second trimester
 - O26.851 Spotting complicating pregnancy, first trimester
 - O26.852 Spotting complicating pregnancy, second trimester
 - O26.853 Spotting complicating pregnancy, third trimester
 - O26.85 Spotting complicating pregnancy, unspecified trimester

Be careful when reporting an annual GYN exam

 Code Z01.4- denotes an encounter for a routine GYN exam, including the following:

- Encounter for general GYN exam with or without cervical smear
- Encounter for GYN exam (general) (routine), not otherwise specified
- Encounter for pelvic exam (annual) (periodic)

 Coding Examples

- Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings
- Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings
- Z01.42 Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear

 Physicians must document whether the exam is with or without abnormal findings, as this affects code assignment

- Physicians can bill an E/M code in conjunction with the appropriate ICD-10-CM code for this visit, however, only the lab can bill for the cervical smear test itself

Access to a translator.

- <https://www.aapc.com/icd-10/codes/>
- <http://www.icd10codesearch.com/>
- Will map ICD-9 CM code to the closest matching ICD-10 CM code.
- Will map ICD-10 CM code to the closest matching ICD-9 CM code.

Clinical Documentation Improvement Webcasts


- <http://www.roadto10.org/webcasts/>

Information about ICD-10 published by CMS www.cms.gov/icd10

Additional Information

 Email: info@patagoniahealth.com

 Website: www.patagoniahealth.com

 Phone: 919.238.4780

 Additional Resources:

- Demo Videos <http://patagoniahealth.com/resources/videos/>
- Customer Videos <http://patagoniahealth.com/customers/customer-videos/>
- Case Studies <http://patagoniahealth.com/customers/case-studies/>

 Download this presentation and ICD-10 CM cheat sheets at <http://patagoniahealth.com/resources/white-papers/>