Preparing for ICD-10

VT Medicaid
Department of Vermont Health Access
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VT Insurer Are Working Together!

Department of Vermont Health Access in cooperation with.....

Vermont Office of Rural Health and Primary Care, Blue Cross Blue Shield of Vermont, Cigna, & MVP Health Care
ICD-10 Questions, Insurer Contacts!

Insurers:

DVHA website:  http://dvha.vermont.gov/for-providers/icd-10/

BCBSVT website:  http://www.bcbsvt.com/provider/resources/icd-10

Cigna website:  www.CignaforHCP.com > Resources > Medical Resources > Communications > HIPAA 5010/ICD-10 Updates

MVP website:  http://www.mvphealthcare.com/provider/ICD10_updates_and_faqs.html

Office of Rural Health and Primary Care efforts:

- Information on training at discounted rates, contact John.Olson@state.vt.us
- Take our online statewide survey to give us your feedback on ICD-10. Link to http://survey.healthvermont.gov/s3/icd10-gen
1. A Brief Background on ICD-10
2. Why Documentation Will Be Critical
3. A Roadmap to ICD-10 Implementation
4. How Payers are Preparing for ICD-10
A Brief Background on ICD-10

- International Classification of Diseases, 10\textsuperscript{th} Edition (ICD-10) starts 10/1/15
- Implementation is a hard cutoff
- All HIPAA covered entities must comply
- ICD-10 includes both ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures)

**Resource:**
<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>Approx 14,000 Codes</td>
<td>Approx 69,000 Codes</td>
</tr>
<tr>
<td>Up to 5 characters all numeric (except for the 1st char “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, sequelae, 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, 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 within structural change.</td>
</tr>
<tr>
<td>Consistency of terms and definition challenging</td>
<td>Consistency of terms and concepts improved</td>
</tr>
<tr>
<td>Combination codes are limited</td>
<td>Combination codes are frequent, with multiple distinct medical concepts per code.</td>
</tr>
<tr>
<td>ICD-9 CM Procedure Codes (Vol. 3)</td>
<td>ICD-10 PCS Codes</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Approx 4,000 Codes</td>
<td>Approx 72,000 Codes</td>
</tr>
<tr>
<td>3 to 4 characters all numeric</td>
<td>7 characters all of which could be alpha or numeric characters. All 7 characters required.</td>
</tr>
<tr>
<td>Not structured</td>
<td>Highly structured</td>
</tr>
<tr>
<td>Diagnosis occasionally included</td>
<td>Diagnosis not included</td>
</tr>
<tr>
<td>Common use: NEC (not elsewhere classified) and NOS (not otherwise unspecified)</td>
<td>NEC and NOS are uncommon</td>
</tr>
<tr>
<td>Eponyms (named after) used frequently</td>
<td>Eponyms rarely used</td>
</tr>
<tr>
<td>General body locations</td>
<td>Detailed body locations</td>
</tr>
<tr>
<td>Combination codes used frequently</td>
<td>Combination codes are rare</td>
</tr>
<tr>
<td>Common medical terminology</td>
<td>Completely new medical terminology model</td>
</tr>
</tbody>
</table>
ICD-10-CM Format

XXX • XXX X

Category

Etiology, anatomic site, severity

Extension
Examples of ICD-10-CM (ER)

I10 Essential (primary) hypertension
S01.02xA Laceration with foreign body of scalp, initial encounter
S01.02xD Laceration with foreign body of scalp, subsequent encounter
S01.2xxA Fracture of nasal bones, initial encounter for closed fracture
H65.01 Acute serous otitis media, right ear
H65.02 Acute serous otitis media, left ear
H65.03 Acute serous otitis media, bilateral
ICD-10 Changes in Terminology

<table>
<thead>
<tr>
<th>ICD-9 Term</th>
<th>ICD-10 Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bunionectomy</td>
<td>Resection of Metatarsal</td>
</tr>
<tr>
<td>Amputation</td>
<td>Detachment</td>
</tr>
<tr>
<td>Arthroscopy, Cystoscopy…</td>
<td>Inspection… Endoscopic Approach</td>
</tr>
<tr>
<td>Incision</td>
<td>No Term</td>
</tr>
<tr>
<td>Closed Reduction</td>
<td>Reposition (also repair) of (right or left) ,</td>
</tr>
<tr>
<td></td>
<td>(percutaneous, endoscopic, external)</td>
</tr>
<tr>
<td>Radical Mastectomy</td>
<td>Resection (right, left or bilateral)</td>
</tr>
<tr>
<td>Subtotal Mastectomy</td>
<td>Excision</td>
</tr>
<tr>
<td>Tracheotomy</td>
<td>Bypass</td>
</tr>
<tr>
<td>Cesarean section</td>
<td>Extraction of Products of Conception</td>
</tr>
<tr>
<td>Debridement</td>
<td>Excision, Extraction, Irrigation, Extirpation</td>
</tr>
</tbody>
</table>
Use of the term “unspecified” not like ICD-9; may mean only one of many concepts is unspecified

S82202J – Unspecified [fracture] of [shaft] of [left tibia], [subsequent encounter] for [open fracture] [type IIIA, B or C] with [delayed healing]

In example above, multiple details (in red) are specified and only fracture type is unspecified
“Unspecified” may not be used, but does not mean code is specific

C7641 – Malignant neoplasm of right upper limb

M4837 – Traumatic spondylopathy, lumbar region

More characters ≠ more specificity

J60 – Coalworker’s pneumoconiosis

S069X9A – Unspecified intracranial injury with loss of consciousness of unspecified duration, initial encounter
**Coding Specificity**

Common terms in ICD-9 may map to less common terms in ICD-10

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7580</td>
<td>Down's syndrome</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q909</td>
<td>Down's syndrome, unspecified</td>
</tr>
<tr>
<td>Q901</td>
<td>Trisomy 21, mosaicism (mitotic nondisjunction)</td>
</tr>
<tr>
<td>Q922</td>
<td>Partial trisomy</td>
</tr>
<tr>
<td>Q928</td>
<td>Other specified trisomies and partial trisomies of autosomes</td>
</tr>
<tr>
<td>Q929</td>
<td>Trisomy and partial trisomy of autosomes, unspecified</td>
</tr>
<tr>
<td>Q900</td>
<td>Trisomy 21, nonmosaicism (meiotic nondisjunction)</td>
</tr>
<tr>
<td>Q902</td>
<td>Trisomy 21, translocation</td>
</tr>
<tr>
<td>Q920</td>
<td>Whole chromosome trisomy, nonmosaicism</td>
</tr>
<tr>
<td>Q921</td>
<td>Whole chromosome trisomy, mosaicism</td>
</tr>
</tbody>
</table>
Why Documentation Will Be Critical

• May affect ultimate payment - severity, co-morbidities, complications, sequelae, manifestations, causes

• A large number of ICD-10-CM codes only differ in one parameter
  - Left vs. right side of the body
    - M00.141 Pneumococcal arthritis, right hand
    - M00.142 Pneumococcal arthritis, left hand
  - Initial vs. subsequent encounter
Why Documentation Will Be Critical

- How much do we need to prepare? Assess current documentation

Consider the following:
- Engage physicians early in education (5 minute online modules available)
- Run trial coding in ICD-10 now
- Does medical record documentation need improvement?
Potential resources to assist you

- WEDI ICD-10 Roadmap Tool Kit is here
  http://www.wedi.org/knowledge-center/resource-view/resources/2013/07/02/icd-10-roadmap-tool-kit

- CMS Transition Checklists and Implementation Guides
  http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html
Roadmap to ICD-10 Implementation

1. Conduct a risk-driven assessment
2. Assess financial risk of ICD-10 change
3. Build current metrics as future benchmarks
4. Outreach with key relationships
5. Develop comprehensive data strategy
6. Educate your staff
7. Conduct testing
8. Plan for contingencies
Step 1: Conduct an Assessment

- Don’t start from scratch – use lessons learned from others
- Discover early the high risk areas; go deep
- Set priorities and “must do” items based on process risk or financial exposure
- Vendor considerations
- Staff skill level and expertise
Step 2: Assess Financial Risk

- Rates of claims pended or denied by payers; auto-adjudication reductions
- Performing an analysis of your top revenue drivers (high dollars, high volume, high risk)
- Consider the 80/20 rule on your revenues to prioritize your focus
Step 3: Build Metrics

Start building baseline metrics now to measure against future performance at Go Live:

- Number of physician queries, response time, aged backlog
- Percent of queries vs. chart reviews
- Coder productivity rates, accuracy rates
- Aging of A/R by Payer in days and dollars
- First pass resolve
- Number and type of rejects/denials by payer
Step 4: Conduct Outreach

- Communicate regularly with key relationships to ensure everyone is on track as you expect
- Determine which payers are willing to test with you, the type of testing involved, and the timing of testing
Step 5: Develop a Data Strategy

Data Strategy Options
- Is there agreement on clinical definitions?
- Is there a need to convert history? If yes, from ICD-9 to -10, ICD-10 to -9, or both?

Prepare a report inventory
- Retire old reports?
- Create new ones?
- Ad Hocs?
Step 6: Educate Staff

- Staff training specific to their role
- Training should be “just in time”
- Will coding/validation staff need additional specialty training, e.g. terms?
- Validate where you need to update checklists, “cheat sheets” or templates used in coding
Step 7: Conduct Testing

- This is not like 5010 testing -- prepare
- Define test scenarios as clinical, real world cases, not just EDI transactions
- Each provider payer processing path may be unique
- Not feasible to test with everyone
Step 8: Plan for Contingencies

- Impacts to cash flow – consider a line of credit
- Will payers require more prior auths?
- Expect overtime/additional staff need
- What if your vendor is not ready?
- Develop a process to manage errors
New CMS-1500 Paper Claim Form
Billing Instructions – VT Medicaid

- For the CMS1500 version 02/12 paper claim form:

  - Field 15 (Accident Date) – Must be entered in field 15 using the qualifier “439”. (The accident date was in field 14 on the 08/05 form.)
  - Field 17 (Name of Referring Provider or other source) – Until further notice, use qualifier “DN” only. Example: If you are entering an ordering physician, do not use the ordering qualifier; use the “DN” qualifier.
  - Field 21 (ICD Indicator) – Enter a “9” if you are using ICD-9 diagnosis codes. Enter a “0” if you are using ICD-10 diagnosis codes. (NOTE: ICD-10 codes are not valid until 10/1/2015.)
  - Field 21 (Diagnosis codes A-L) – Now able to enter up to 12 diagnosis codes in this field. (NOTE: The pointer character has changed from numbers to letters.)
  - Field 24-E (Diagnosis Pointers) – Must now use the corresponding letter to denote which diagnosis code(s) you are pointing to.
New CMS-1500 Paper Claim Form  
Billing Instructions – VT Medicaid

- At this time, Vermont Medicaid has not adopted any other changes in the new CMS1500 version 02/12 paper claim form.

- Vermont Medicaid, starting with claims received on 4/1/2014, will only accept the new CMS1500 version 02/12 paper claim form.

Note: These changes do not affect electronic billing. Please continue to bill as directed in the Provider Manual.
How VT Medicaid is Preparing

- Conducted internal MMIS system & UAT testing
- 1500 Paper claim form 2012 implemented April 1, 2014
- “Spreading the word”, education
- Website: [http://dvha.vermont.gov/for-providers/icd-10/](http://dvha.vermont.gov/for-providers/icd-10/)
- End-to-End testing with clearinghouses and providers (projected to start in 2015)
- Ongoing outreach