ICD-10-CM
State of Transition

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We’ve Transitioned – Now What?
Transition Expectations

ICD-9 Productivity

- Coder productivity first 12 months:
  - 70% longer to code claims
  - 54% decrease in productivity

  **Note:** Canada’s data indicates initial productivity loss is never fully recovered

- Coder productivity in the long term:
  - 20% decrease in productivity
  - Maintain a 95% > accuracy rating
# Productivity Comparison

<table>
<thead>
<tr>
<th>ICD-9 Current</th>
<th>ICD-10 First 12 months</th>
<th>ICD-10 Long term</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coding:</strong></td>
<td><strong>Coding:</strong></td>
<td><strong>Coding:</strong></td>
</tr>
<tr>
<td>25 assessments daily</td>
<td>11.5 assessments daily</td>
<td>20 assessments daily</td>
</tr>
<tr>
<td><strong>Coding and OASIS Review:</strong></td>
<td><strong>Coding and OASIS Review:</strong></td>
<td><strong>Coding and OASIS Review:</strong></td>
</tr>
<tr>
<td>15 assessments daily</td>
<td>6.9 assessments daily</td>
<td>12 assessments daily</td>
</tr>
<tr>
<td><strong>Internal audit Review:</strong></td>
<td><strong>Internal audit Review:</strong></td>
<td><strong>Internal audit Review:</strong></td>
</tr>
<tr>
<td>95% &gt; accuracy rating</td>
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</tr>
</tbody>
</table>

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# What type of company do you work for?

- Nonprofit
- Corporate-owned agency
- Hospital-owned
- Freestanding agency
- Outsource coding company

![Bar chart showing the distribution of types of companies]

- Nonprofit: 30%
- Corporate-owned agency: 20%
- Hospital-owned: 10%
- Freestanding agency: 40%
- Outsource coding company: 5%
What is your average daily census?

- Less than 50
- 59 to 199
- 191 to 260
- 261 to 360
- 361 to 480
- 401 to 599
- 501 to 1,000
- More than 1,000

Did your organization begin dual coding on August 3, 2015?

- Yes
- No
What percentage of charts are dual coded?

- 8 to 25%
- 26 to 50%
- 51 to 75%
- 76 to 99%
- 100%

Are you experiencing a productivity decline?

- Yes
- No
What percentage has productivity declined?

- Less than 10%
- 10 to 24%
- 25 to 49%
- 50 to 74%
- 75% or greater

What reason do you attribute the productivity loss?

- Coders' knowledge...
- Clinical documentation...
- Referral source...
- Software vendor not...
Impact Ranking (1 to 5) 
5 representing > impact

<table>
<thead>
<tr>
<th>Reason</th>
<th>1 Least</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Most</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coder knowledge deficit</td>
<td>13.89%</td>
<td>22.22%</td>
<td>28.70%</td>
<td>15.74%</td>
<td>19.44%</td>
</tr>
<tr>
<td>Clinical documentation deficit</td>
<td>1.83%</td>
<td>10.09%</td>
<td>30.28%</td>
<td>27.52%</td>
<td>30.28%</td>
</tr>
<tr>
<td>Referral source documentation deficit</td>
<td>5.56%</td>
<td>10.19%</td>
<td>13.89%</td>
<td>31.48%</td>
<td>38.89%</td>
</tr>
<tr>
<td>Software vendor readiness</td>
<td>37.38%</td>
<td>22.43%</td>
<td>19.63%</td>
<td>6.54%</td>
<td>14.02%</td>
</tr>
</tbody>
</table>

Has your agency started auditing ICD-10 coding accuracy?

Yes: 42%  
No: 58%  

13 | Title of Presentation

14 | Title of Presentation
Audit Findings

- Coding knowledge...
- Clinician documentation
- Referral documentation
- Physician documentation

Coder Productivity Comparison

<table>
<thead>
<tr>
<th>ICD-9 Daily Assessments</th>
<th>Survey Percentage Decrease</th>
<th>ICD-10 First 30 days Low/High</th>
<th>ICD-10 First 30 days Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>&lt; than 10%</td>
<td>22</td>
<td>22</td>
</tr>
<tr>
<td>10 to 24%</td>
<td>19 to 22</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>25 to 49%</td>
<td>18 to 25</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>50 to 74%</td>
<td>6 to 12</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>75% or &gt;</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>95% &gt; accuracy rating</td>
<td>72% accuracy rating</td>
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## Coder Productivity Comparison

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<tr>
<td>10 to 24%</td>
<td>11 to 13</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>25 to 49%</td>
<td>7 to 11</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>50 to 74%</td>
<td>4 to 7</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>75% or &gt;</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>95% &gt; accuracy rating</td>
<td>72% accuracy rating</td>
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</tr>
</tbody>
</table>

## Summary of Findings

<table>
<thead>
<tr>
<th>Error</th>
<th>Percentage</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invalid code(s)</td>
<td>27.49%</td>
<td>Coding Specialist Error</td>
</tr>
<tr>
<td>Inaccurate code(s)</td>
<td>72.51%</td>
<td>Documentation Deficit</td>
</tr>
</tbody>
</table>
Education Touch Points

- Coding specialist knowledge deficit
- Clinician documentation deficit
- Physician documentation deficit
- Referral source documentation deficit

Coding Errors
Knowledge Gap

- Anatomy
- Physiology
- Pathophysiology
- Pharmacology
- Medical terminology

Coding Specialist

- Review 100% of coding specialist codes
- Focus on most common errors
- Affected resource utilization
- Coding education improvement plan
- Facilitate coder and clinician interactions
- Consider developing a mentoring program
Common Coding Errors

- 7th character missing
- Laterality missing
- Ulcer severity missing
- Sequencing errors
- Unspecified codes
- Invalid codes

Documentation Deficits
Documentation

• The home health plan of care is required to contain all pertinent diagnoses affecting the patient's responsiveness to treatment and rehabilitative prognosis even if the condition is not the focus of any home health treatment itself

Documentation

• Home health is obtaining records and documentation from multiple sources prior to coding/billing the RAP
  - Referral source
  - Hospitals
  - Physicians
  - Home health clinicians
Clinician

- Review 100% of clinician documentation
- Focus on most common documentation deficits
- Affected resource utilization
- Documentation improvement plan
- Facilitate coder and clinician interactions
- Consider developing a mentoring program
Common Documentation Deficits

- General documentation deficits
  - Laterality not documented
  - Ulcer severity not documented
  - Fracture specificity not documented
  - Type of dementia not documented
  - Type of heart failure not documented

Importance of Intake Team
Sample Intake Tool

<table>
<thead>
<tr>
<th>Diagnosis/Condition</th>
<th>Sample Query Questions</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fractures</td>
<td>Could you provide the radiology report that includes the location and type of fracture?</td>
<td>PCP H&amp;P report</td>
</tr>
<tr>
<td>- site</td>
<td></td>
<td>Surgical report</td>
</tr>
<tr>
<td>- closed/open</td>
<td></td>
<td>Radiology report</td>
</tr>
<tr>
<td>- laterality</td>
<td></td>
<td>Discharge summary</td>
</tr>
<tr>
<td>- routine/delayed healing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart failure</td>
<td>Does the CHF have a diastolic or systolic component?</td>
<td>Cardiologist report</td>
</tr>
<tr>
<td>- systolic</td>
<td></td>
<td>PCP H&amp;P</td>
</tr>
<tr>
<td>- diastolic</td>
<td></td>
<td>Cath/other procedures</td>
</tr>
<tr>
<td>- congestive</td>
<td></td>
<td>report</td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td>Is the osteo from a soft tissue injury or blood infection?</td>
<td>PCP H&amp;P report</td>
</tr>
<tr>
<td>- acute</td>
<td></td>
<td>Radiology report</td>
</tr>
<tr>
<td>- chronic</td>
<td></td>
<td>Discharge summary</td>
</tr>
<tr>
<td>- hematologic/other</td>
<td></td>
<td>Surgical report</td>
</tr>
<tr>
<td>- manifestation vs. non</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Documentation

• The physician is legally accountable for establishing the patient’s diagnoses
• Physician practices were recently given a 12 month grace period
• “If a valid ICD-10 code from the right code family is submitted, Medicare will process and not audit the code selection”

Documentation

• Physicians are not paid from ICD-10 codes
• Physicians utilize ICD-10 codes to establish medical necessity
• Sense of urgency to provide more robust documentation has diminished
• Home health’s reimbursement is dependent on the classification system
Clinical Documentation Improvement

• CDI has arrived on the doorstep of HH
• Purpose is to review concurrently and retrospectively for conflicting, incomplete, or nonspecific documentation
• The goal of a CDI program is to identify clinical indicators that ensure diagnoses are supported by the ICD-10 codes
• Documentation is translated into ICD-10 codes

CDI Background

• CDI programs began in the 1990s to assist physicians in their documentation efforts
• October 2007 CMS implemented severity and risk of mortality to hospital DRGs
• October 2008 CMS required Present of Admission (POA) indicators for all diagnoses
• Hospitals have ramped up their CDI programs
CDI

• Physician participation in hospital CDI programs is required
• Compliance statistics are kept per physician in a hospital setting
• High level provider documentation is required in a hospital setting and it is now on the doorstep in a home health setting

Getting Started

• Create a CDI team
• Should not be part of the coding department
• The team member(s) should work closely with the coding specialists, clinicians, physicians
• Direct liaison to physicians
• Develop CDI policies and procedures
• Conduct initial comprehensive chart review
Getting Started

- Review the data by physician and agency clinician for incomplete documentation
  - physician deficit?
  - clinician deficit?
  - identify the HHRG billed
  - determine what the HHRG could have been with additional documentation
- Initial review is basis of a documentation handbook for the CDI professional

Top 3 Challenges

Physician buy in

- Education of physicians is a prerequisite
- Education should be tailored to specific referral type (cardiology, endocrine etc)
- CDI liaison should emphasize the benefits for the physician including defensible documentation and outcome data
Top 3 Challenges

Hiring the right CDI Professional

• Can come from various backgrounds
• Clinical background
• Strong oral and written communication skills
• Basic knowledge of coding guidelines and conventions
• Understand the ethics and compliance issue surrounding the query process

Top 3 Challenges

Bridging the Gap

• CDI team/agency staff/physicians
• CDI professional is new kid on the block
• CDI role is to communicate with physicians on documentation improvement issues concurrent with the admission
• A role that has been the clinician or coder
• Recognize each other’s skill sets
• Work as partners to accomplish accurate documentation
7th Character ‘A’
Hullabaloo

Coding Guideline Revision

• For complication codes, active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating problem.
• For example, code T84.50XA, Infection and inflammatory reaction due to unspecified internal joint prosthesis, initial encounter, is used when active treatment is provided for the infection.
• Even though the condition relates to the prosthetic device, implant or graft that was placed at a previous encounter.
Unintended Consequences

• Prospective payment system for home health was developed as a subsequent care model
• Grouper Logic calculates case mix points and NRS points only if the 7th character is a ‘D’
• Many home health software systems do not recognize a 7th character of ‘A’
• Decreased clinical severity
• Decreased reimbursement

T81.31x-Dehiscence Example

<table>
<thead>
<tr>
<th>Case Mix points</th>
<th>Equation 1</th>
<th>Equation 2</th>
<th>Equation 3</th>
<th>Equation 4</th>
<th>NRS points</th>
</tr>
</thead>
<tbody>
<tr>
<td>P/Sx ‘A’</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Primary ‘D’</td>
<td>4</td>
<td>21</td>
<td>8</td>
<td>19</td>
<td>23</td>
</tr>
<tr>
<td>Secondary ‘D’</td>
<td>6</td>
<td>15</td>
<td>7</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>M1030</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>n/a</td>
</tr>
</tbody>
</table>
Now What?

• Meeting with Dr. William Rogers, CMS ICD-10 Ombudsman
• Look for clarification in PPS 2016 Final Rule
• Be aware of the consequences for your agency or organization
• Stay tuned for further clarification

Association of Home Care Coding & Compliance (AHCC)

Community of professionals dedicated to providing quality care, and to establishing, meeting, and maintaining standards of excellence through rigorous credentialing process
AHCC

AHCC’s commitment to the industry, includes

• Education and training
• Credentialing and certifications through BMSC
• Advocacy
• Career development and networking
• Industry resources and tools

Professional credentials

Require staff to be credentialed

• Validates body of knowledge, and ability to apply what they know
• Evidences a professional and personal commitment to excellence
• Increases agencies productivity and profitability
Credentialing Alphabet Soup

**AHIMA**
- RHIT – Registered Health Information Technician
- CCA – Certified Coding Associate
- CCS – Certified Coding Specialist
- CCS-P – Certified Coding Specialist-Physician-based

**AAPC**
- CPC – Certified Professional Coder
- COC – Certified Outpatient Coding
- CIC – Certified Inpatient Coder
- CRAC – Certified Risk Adjustment Coder
- CPC-P – Certified Professional Coder – Payer
- SCC – Specialty Coding Certification

<table>
<thead>
<tr>
<th>HCS-D Competency Areas</th>
<th>BCHH-C Competency Areas</th>
<th>HCS-O Competency Areas</th>
<th>COS-C Competency Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Accurate diagnosis code assignment</td>
<td>2. Diagnosis coding</td>
<td>Validate the accuracy of OASIS responses</td>
<td>2. Patient populations</td>
</tr>
<tr>
<td>3. Collaboration with clinicians and physicians supporting code assignment</td>
<td>3. OASIS assessment</td>
<td>Correct OASIS response errors according to OASIS guidance and documentation standards</td>
<td>3. OASIS related regulations</td>
</tr>
</tbody>
</table>
Ensure staff capabilities

Identify skills gaps
• Audit charts
• Periodic staff assessments
• Teach to individual and system-wide gaps
• Credential staff

Continuous training

Training is not once and done, establish a continuous improvement program
• Codes change annually
• Coding clinic Q&A release quarterly
• Guidance changes periodically
• OASIS Q&A release quarterly
• Expertise takes time, individuals progress at different rates
ICD-10 Transition Support

- Consultants
- Trusted partners
- Software vendors
- CMS ICD-10 Coordination Center
- CMS ICD-10 Ombudsman
- ICD-10 Transition Workgroup
  
  AHHQI       NHPCO       VNAA
  AHCC        NAHC

CMS ICD-10 Ombudsman and Coordination Center

Presented as “one-stop” shop for all health care providers

This center is responsible for coordinating post-implementation operations with a focus on delivering a high quality experience for internal and external stakeholders
CMS ICD-10 Ombudsman and Coordination Center

Recommended steps for problem resolution:

Step 1 – For general ICD-10 information, go to CMS ICD-10 website and Road to 10 website

Step 2 – Contact the MAC for Medicare claims questions

Step 3 – Contact the ICD-10 Ombudsman with general implementation questions

Home Health and Hospice ICD-10 Transition Workgroup

Working collaboratively to support transition to ICD-10

• Invite members to submit ICD-10 concerns, including coding questions
• Review and aggregate questions to send single query to CMS and to Coding Clinic, as appropriate
• Work through ombudsman to ensure prompt response by CMS
• Petition Coding Clinic to give home health and hospice a seat at the table
• Communicate query response back out to the industry through member associations
• Archive of Q&A to live on AHCC website
Questions

Contact Information

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