ICD-10 Documentation Requirements

Rural Health Clinic Technical Assistance Series Call
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Moderator: Bill Finerfrock

Coordinator: Good afternoon and thank you all for holding. Your lines have been placed on a listen-only mode until the question and answer portion of today's conference. And I would like to remind all parties the call is now being recorded. If you have any objections please disconnect at this time.

And I would now like to turn the call over to Bill Finerfrock. Thank you, sir, you may begin.

Bill Finerfrock: Thanks, Yolan. And I want to welcome all of our participants. My name, as she said, is Bill Finerfrock and I'm the Executive Director of the National Association of Rural Health Clinics and I'm the moderator for today's call.

Let me take a moment to remind you to try and get in an area where it's quiet and secure but your phone lines will be muted so you don't have to worry - you shouldn't have to worry about background noise.

Today's topic is ICD-10 documentation requirements. And we're pleased to introduce Dr. Joe Nichols, a recognized expert on physician coding and documentation.

Dr. Nichols is a Board-certified orthopedic surgeon who's been in healthcare for over 35 years. For the past 15 years he's been full time in healthcare IT, has been involved in product management, database design, quality metrics and other healthcare data-related activities.

He also has spent five years as the CEO of a Medicaid third-party administrator company and he currently co-chairs three sub groups for WEDI, which stands for the Workgroup for Electronic Data Interchange. He's given numerous national presentations for payers and providers and received the WEDI merit award in 2009 and 2010.

He'll give us a brief overview of some of the ICD-10 requirements but most importantly talk with us about the documentation requirements for ICD-10. I want to note that this series is part of our ongoing series sponsored by the Health Resources and Services Administration Federal Office of Rural Health Policy in conjunction

with the National Organization of State Offices of Rural Health and the National Association of Rural Health Clinics.

Today's call is the 55th in our series which began in late 2004. During that time we've had over 14,800 combined participants on these bimonthly calls. As you all know there's no charge to participate in this series and we encourage you to refer others who might benefit from the information to sign up to receive the announcements.

During the Q&A period we ask that the callers please provide their name, city and state before asking their question. And note that if you'd like to, in the future, email questions or topic ideas and send them to info - I-N-F-O - @narhc.org and put RACTA Question in the subject line.

Dr. Nichols, I'd like to turn the program over to you and we look forward to your remarks. And at the end we'll open it up and the operator will give instructions for questions.

Joe Nichols: Thank you, Bill. I appreciate the opportunity to talk to your group. We're going to go through these slides fairly quickly because there's a lot of material here and we probably want to save as much time as we can for questions at the end. But you should have all of this information for review so we'll get started here.

If you go to Slide 2 it sets out the agenda for what we're going to discuss. The assumption going in is that you have some basic knowledge of what ICD-10 is and how it's different. We're not going to review all of those basics again because I believe most folks have at least had the opportunity to take a look at that.

We really want to focus on how will it impact your business? What's the role of physician and office practice managers? What do you need to do to prepare for this? In particular we want to focus a lot on why is clinical documentation and good coding important? How can you identify what needs to be documented?

What are some of the strategies for reducing the apparent burden on the physician? And how much can you do to make sure the documentation quality and coding is achieved and maintained over a period of time?

So if we go to Slide 3, this is the first slide that illustrates some of the business impacts. I'm sure a lot of you have already looked and realized that coding, electronic health record updates, training, coding software, are all things that are going to be significant business impacts moving through this transition which I think is one of the biggest changes we've seen in many years in healthcare information.

Contracting may change, case rates, carve outs, certainly billing will change, billing code updates, billing edits, charge masters if you have those, benefits and coverage determinations may be very different under ICD-10.

I have been part of a team to support State Medicaid agencies in their transition - I think we just finished our 42nd state - talking to the state Medicaid agencies about how the definition of benefits and coverage are going to change substantially because we've redefined those patients.

In Slide 4 we just continue with some of the impacts in terms of just being compliant. This is a HIPAA law. It requires that everyone be compliant as of October 1, 2014, essentially a year from now.

This is based off of date of services or date of discharge and applies to every payer - including Medicaid, and Medicare, every provider, every clearinghouse that submits HIPAA- transactions is a covered entity and must comply with this.

This may have impacts beyond HIPAA to reporting, national, state, regional type of initiatives, contract requirements, accreditation. We may also see impacts on reimbursement, pay for performance, never events, readmissions; hospitals acquired conditions and other initiatives.

Many payers are looking at who do they include in their network based off of quality measures. We may see changes in denials based off of coverage decisions. So there is a reimbursement impact even though we don't pay directly on these codes, these codes factor in to the payment and will do so a lot more in the future.

Audits are certainly increasing, RAC audits, coding audits of all kinds. Having accurate documentation to support accurate coding is going to be even more important as we move into this next phase.

If we go to Slide 5 I have tried to summarize the role of the clinical, business and coding areas in a practice, and how those relationships are changing. The role of the clinician really is to document as accurately as possible the nature of the patient's condition and the services done to maintain or improve those conditions.

The guides for coding are very explicit. They say that the code should always represent, as accurately as possible, what the patient's condition is. Coding for billing purposes is really not appropriate. Coding is to represent as accurately as possible what the patient's condition is.

The role of the coding professional is to assure that the coding is consistent with the documentation. And the role of the business manager is to assure that all the billing is accurately coded and supported by the documented facts. Otherwise audits may result in recovery of paid dollars.

If we move to Slide 6 we're going to talk a little bit about transition. What do you need to do? What are some of the key questions you need to ask as you're moving into this transition? And hopefully you've already started this because a year is not a lot of time to get all of this pulled together.

So if we go to Slide 7 one of the first questions you want to ask is what are the moving parts of your practice? What are the things that impact you that are important to your practice? And in order to answer that question you have to create an inventory of what are all the functional aspects of the practice?

Determine those areas that might be directly or indirectly impacted by those codes and then begin to prioritize those areas based off of cost or volume or clinical or business importance. You may not be able to address all areas perfectly so understanding where the key hotspots are and understanding where the impacts are, will help you define where you need to prioritize effort.

Slide 8 we ask the question, "Where are your dependencies?" And in order to address that, you have to inventory all those areas where you have a dependency that may impact your ability to successfully implement ICD-10 whether it's payers, other providers you deal with, software vendors, regulatory agencies, any internal and external resources critical to your business.

You want to know where those dependencies are and where they are in terms of doing the things they need to do to support you.

Slide 9, the question is, "Who needs to understand ICD-10?" Well, you need to really identify those persons by role who may be impacted by ICD-10 or the documentation needed to support proper coding.

Coding can only be as good as the documentation supporting it, and so persons who are responsible for gathering that documentation and for the coding, all need to have a fairly good understanding of what this new thing is and how it's different from what we've been doing in the past.

You also need to define your approach to education. Are you going to do a train the trainer approach where someone within the organization is going to get well trained on ICD-10 and then pass that knowledge on? Are you going to be looking at role-

based education that says we have the right level of information with the right focus and content at the right time?

I know a lot of physicians, for example, aren't really interested in coding; their primary role is going to be in documentation. And the coders are going to need that documentation to go forward. Coders may need a different level, business persons may need a different level.

But almost everyone is going to be impacted some way. And what is the training that's going to be provided? How will you know if the training was successful or not? Is there a way to test that within your organization?

On Slide 10 we ask the question, "What do I need to do to implement?" In order to answer that question, you have to identify a specific task, based on an analysis of the business and clinical areas that either are directly or indirectly impacted by ICD-10.

Almost everything we do relate to a patient condition or service. The claims we generate will directly or indirectly relate to some ICD-10 code.

Identification and prioritization of those areas that are critical to your business. This may be high-dollar, high-volume and it may be areas of high complexity or areas that are important or areas where there is a compliance requirement, analysis of what are your key dependencies.

In addition you need to have a realistic project plan where you've taken those tasks – that you organize in such a way that timing, priority and critical path dependencies are known, so that this can actually be accomplished. Identify and assign resources, execute and measure progress. A good project plan must be doable and it needs to be comprehensive to cover all the things that need to be covered.

Next question you might ask is how do I know my efforts are working? Well in order to do that you need to define and implement test cases that are consistent with those areas that are important; high volume, high dollar, key business or clinical importance.

You need to identify what you need to measure for success. Is coding accurate? How are you going to measure that? Is coding specific? How do you measure coding specificity? To what degree is financial continuity maintained? Is what we were billing before compared to what we got paid changed? Is the denial rate changed? Is the rejection of claims changed? So there are some key things that need to be understood.

One of the things that is very helpful to do, since we've never used ICD-10 before is to take those things that we're familiar with today and create a scenario. We identify something that we do on a regular basis that's not going to change between now and October 1. But how will that event or condition be recorded? How will it be documented? How will it be coded as we move into this new environment?

And then we try and recreate that event virtually. We're not in ICD-10 yet but we're walking through the pathways. Kind of like doing a fire drill where, you know, we don't have an actual fire but we dress people up, we go through the steps to try and identify where are those areas we need to focus on? Where are the gaps? Where are the specific tasks that need to be done?

Defining a variety of assumptions about those particular scenarios helps us use the same scenario and then apply different parameters. This process of walking through your current workflow using ICD-10 is called a reference implementation model, we walk through our current systems or processes using these scenarios with different assumptions about different payers, different variables, different types of patients, and then determine if the expected results can be achieved given the changes that we've implemented.

So we've kind of done that fire drill or disaster drill, so to speak, to see whether we've left anything out.

In Slide 13 we talk a little bit about what are some of the key financial metrics? If you're going to be going through this change there is a high likelihood that payment models might be impacted. We may see challenges in terms of getting claims out the door, and payers may have some challenges in remediating their rule so that they pay appropriately.

There is a significant chance we could see increased levels of denials and rejections if payers are not ready for this. And we certainly hope they are. But something that needs to be monitored. And in order to do that you need to know what is your current baseline in terms of the rate of claim denials and rejections.

Does this vary by individual provider or business area? And then across this transition period is the rate changing? And where are the changes occurring? Are denial appeals being successful in this new model?

You might also want to look at the ratio of bill to pay. In other words, we're billing a certain amount today, we're getting paid some portion of that back. Has that ratio changed across this period of time? Has what we were paid before changed given the same level and type of services? So looking at those things is important.

As we move to Slide 14 some other financial metrics that you may want to consider looking at payment delays. What is your current claim lag from bill to pay? Is that changing across transition? Are payment lags different by payer?

Looking at audits, are audits increasing or appeals related to adverse and audit findings successful? So a lot to be watching during this transition; this is kind of a risky period and the fact that we're making a major change in how we're defining patients conditions in data, in transactions, can impact a number of different areas so we want to have measures in place to know what the background is and whether there has been a substantial change.

Well let's go to Slide 15. Now as we mentioned there are a lot of new codes; we have almost 69,000 new diagnosis codes where we have 14,000 today. While there are certainly a lot of codes, if we look historically at how we've used codes we only use a very small percentage of the codes.

This is looking at a study of three years of data for one of the Blues in the Midwest. If we look at that analysis, 5% of the codes account for well over 70% of the dollars paid or 70% of the charges. So a very small percentage of the codes account for a very large percentage of what impacts our charges.

We also want to look at those types of conditions that are covered by those codes and look at focusing our efforts in those areas where we see a substantial impact in terms of the numbers. And again it's very skewed: there's a lot of codes and certainly in ICD-10 there will still be a lot of codes that we are unlikely to ever use.

If we move to Slide 16, as we mentioned, ICD-10 codes are increasing fairly dramatically in terms of the number of codes but there's really a reason for that. And that increase is very different in different clinical areas.

In this table what I'm trying to illustrate is that there are substantial differences in clinical areas. For fractures, we see that there's a substantial increase in the number of codes, 747 codes going to 17,000 codes so a very dramatic increase in the number of codes relevant to fractures. And we'll talk a little bit about why that occurs.

For poisoning and toxic effect, the number of codes has also gone up substantially. Pregnancy-related conditions have similarly increased. There are a number of areas where the codes have really not changed greatly. For codes like migraine, for example, we've only added four codes. For bleeding disorders, we've added four codes.

In some areas the number of codes have actually gone down and particularly relevant to behavioral health today we have 78 codes for mood related disorders or affective disorders; in ICD-10 we have 71 so we have less codes. We have half the codes relevant to hypertensive disease that we have today; end stage renal disease, about half the codes. So in some clinical areas the codes are minimally changed or actually have gone down some. In other areas they've gone up substantially.

One of the reasons codes have increased substantially in these other areas is because we have a lot of repeating concepts. In other words, for something like a fracture, for exactly the same fracture, the same detail of the fracture, we have to say whether it's an initial encounter, whether it's a subsequent encounter or sequela so that multiples each fracture code by three.

We also have to state if it involves a side, whether it's right or left. If it's a follow up we have to state if there's normal healing, delayed healing, nonunion or malunion. So multiply those by each and every fracture and you see we end up with a lot of codes.

Similarly for most pregnancy-related codes we have to define the trimester; first trimester, second trimester or third trimester. We didn't have that before so that multiples those codes substantially.

So one of the reasons we see such a large increase in codes it's not because we have new diseases or substantially different concepts. It's really because we now are using codes that contain a lot of information in a single code and so we end up with many multiples that only vary on a few factors.

Let's go to Slide 17. I want to focus a little bit of time talking about documentation. One of the challenges we face with documentation is, it really could be a lot better. I mean, anyone who's looked at clinical documentation, I've certainly looked at a lot of that, will say that we really could do a bit of a better job.

You know, there were things that we were taught in medical school that we should be documenting, all of these details. When we were medical students we documented extensively. And as we got into practice and busier we tend not to document as much but it's still just as important.

And if we don't have good documentation it’s bad for all payers, providers and patients, because it impacts billing accuracy, it impacts quality measures, population management, risk management, healthcare analytics. Most importantly bad documentation is not good for patient care and it's critically important that good patient care remains the primary focus of documentation.

If we move into Slide 18 why is it important? Well it supports proper payment and reduced denials. It helps assure accurate measures of quality and efficiency. What we see in ICD-10 in terms of levels of severity and risk is substantially different than in ICD-9. And that severity in risk is very important in determining the difference in outcomes and quality measures and efficiency.

It helps us address some of those issues around accountability and transparency. It provides us better information about business intelligence, about what type of conditions are we taking care of, has that changed? Have the disease characteristics changed over the population that we're dealing with? Where is the risk associated with those populations?

It helps support clinical research. A lot of clinical research is relying on this type of data with these codes to look at effectiveness. And it will help us enhance communication with hospitals and others that we're involved in with health information exchanges because it is the only national standard we have that crosses all these enterprises that defines the patient's health state and that's going to be critical to everything we do in terms of exchanging information in healthcare.

The most important reason for documentation is just good care. We can't take good care of patients if we don't have good information about the nature of their conditions.

One of the things, if we go to Slide 19, whenever I'm presenting to physician groups I always get this pushback that documentation is really this unnecessary administrative burden caused by ICD-10.

If we look under the covers a little bit though, if we look at what the new concepts are in ICD-10, none of these are new or foreign to clinicians, all of these are concepts that we should be familiar with today. Nothing new has happened. It's just now we're able to capture a lot of these concepts in codes where we were unable to capture those before.

The real focus on documentation is not about ICD-10 coding, it's about good patient care. And if you really look at all of those concepts today there's very few of them that you can't say wouldn't be important in taking care of the patient.

Clearly patients deserve to have accurate and complete documentation of their conditions. For those of us who are becoming more patients then we are providers our perspective on documentation may change. Every time I see my physician I really want to know that he or she has documented important aspects of my condition., I want to know that it's correct, I'm much more interested at this point in time. And, you know, I think all patients deserve accurate and complete documentation.

If you look at other industries the value of accurate and complete documentation of data about encounters and transaction is critically important. And we should be able to document at least as well as other organizations. We wouldn't expect a plumber, for example, to be very vague about what the problem is and what he did and gave us a bill. We'd want to know what the problem was and what was done. And I think patients want the same thing.

So I think a focus on good documentation is not about an ICD-10 administrative burden, it's really about what do we need to do to capture some information that it's important. The bottom line is that it's also necessary for us to code accurately.

If we look at coding it really is, again, all centered the patient interface and the information we gather at the encounter, something happens with that patient, we see them, we do a physical exam, we look at their records, we do studies on that patient, we take a history, we'll do an external record review and we gather all that information and document an assessment of what we think is going on with that patient's condition.

Without that and without complete observation and doing all those things that we were taught in medical school without documenting these important concepts, we can't get to a code. But for a lot of us coding has been - and certainly in my practices in the past it's always been about doing something quick and easy to get that bill out the door. We have our (super) bill, we check a box, we send it to the back office. We may have some queries back and forth.

If we look at Slide 22, this is just an example of an orthopedic (super) bill, one similar to the one that I had in practice that has all of these different codes listed there. And you'll see a section about fractures of the radius. And there's a list of codes there - or fractures of the forearm - there's a list of codes there.

If we look in ICD-9 there were 32 possible codes that could be used for a fracture of the radius. In theory if it wasn't listed here I should use the code that's most appropriate but these are the codes I saw most frequently. In ICD-10 there are 1731 codes for fractures of the radius and the forearm area. So now we're looking at something that would take many pages of a (super) bill to cover all of the codes that might be relevant to conditions that we might see.

The concept of the (super) bill may not work well and particularly in certain specialties because we now simply have too many codes out there that describe very different types of conditions. And it's critical that we document those things going forward.

So let's go to Slide 23. If we're going to be documenting, what are the things that we need to document? And basically these are things, again, that we were taught in medical school. We're going to try and take some of those concepts of documentation and see if we can see how they apply to certain different conditions.

So basically when we're evaluating the patient one of the things we want to know is what type of condition, is it Type 1 or Type 2 diabetes or other type of condition? When was the onset? When did it start? What was the cause? Is this related to an infectious agent, a physical agent, an internal failure, some congenital failure?

We might look at things like anatomical structure. Is it proximal, distal, medial or lateral? Is it in a specific area of a specific bone or a specific area of a specific organ? So we document that. Whether it's right or left, knowing if it was a fracture involving the right arm or the left arm is critically important.

Severity; is it something that's mild, moderate or severe? For certain types of condition are there environmental factors like smoking? Is this related to a geographic location? We might look at things like time parameters? Is it intermittent or paroxysmal? Is it recurring? Is it acute or chronic? Is it post-op, post-delivery?

We might look at things like comorbidities, for example, diabetes with a neuropathic joint. Is there intracranial injury associated with a skull fracture, for example? Manifestations; was one of the manifestations paralysis? Was one of the manifestations loss of consciousness or some other manifestation.

We might be looking at things like healing level. Is it normal healing? Is the healing delayed? Is there nonunion of a bone, for example, or malunion meaning it's healed improperly. So, all of these are basic concepts that we should be documenting today.

So let's move on to looking at Slide 27. And in Slide 27 what I wanted to do is just illustrate that there are a lot of concepts in ICD-10 that recur over and over again. And this is important to know because these concepts that recur impact many codes and we should be capturing that information if we want to get to the right code.

And one of the techniques for trying to reduce the burden is capture this information up front as part of a question when the patient comes in, as part of an interview done by a non-clinician. We're going to need to record this information; why don't we just capture it right up front and not have to capture that during the clinician time.

Things like initial encounter impacts 13,900 codes or whether it's a subsequent encounter, 21,000 codes, whether it's a sequela, 11,000 codes, right versus left. If you

look at all the ICD-10 codes 1/3 of the codes are exactly the same except for right or left, that's the only difference is whether it's right or left. So it's kind of important to capture that because that's going to impact well over 1/3 of the codes.

So let's take a specific condition and let's walk through and say what are the types of concepts - and, again, coding is about documenting key medical concepts - what are the types of concepts we might see in these particular types of conditions and how might those relate to ICD-10 codes?

So if we go to Slide 28 we're going to take something basic like otitis media. And moving on to Slide 29 the first thing we might ask is what type of otitis media is it? Is it serous? Is it suppurative or non-suppurative? Is it tubotympanic type? Is it allergic type? Is it mucoid type? Again, things that we would normally capture in terms of evaluating that patient.

Moving on to Slide 30, there may be a lot of alternative terms we might use like whether it was sanguiness, whether it was exudative, whether it was secretory, all of these things that we might capture in part of that evaluation about the type of otitis media.

Now if we move to Slide 31 we might also document what the condition was it associated with? Was it associated with a spontaneous rupture? Was it associated with some infection or external agent and if so what was it? Was it associated with smoking? Was it associated with some allergic or non-allergic condition?

Slide 32, were there temporal factors involved? In other words, was this acute or sub-acute or was it chronic? Is it recurrent? Laterality, was it left or right or was it bilateral or unilateral?

So, all of these concepts that we might want to capture as part of a normal evaluation of a patient with otitis media. Let's look in Slide 33 at what some of the ICD-10 codes would look like and see what those concepts factor into that code.

So here we are looking at a set of ICD-10 codes relevant to otitis media. And we'll see things like measles complicated by otitis media so we're addressing that issue, what was the infectious agent? Acute serous otitis media, right ear; in this case we're saying that it was acute. It was a serous otitis media and it involved the right ear.

Or we might look at a code like H66012, acute suppurative otitis media with spontaneous rupture of the ear drum of the left ear. We're capturing that it was acute, that it was supportative, that there was a spontaneous rupture and it involved the left ear.

And so as we see these types of concepts repeating in these codes it's really capturing those concepts that are important because we really can't identify the right code if we don't get those concepts documented. If all we say is otitis media and we don't say which ear or we don't say what type of drainage or whether there was a rupture of the membrane, then we're not going to be able to code accurately.

And knowing what those things are is helpful to know what the codes are but more importantly we should probably be capturing all those things today just for good patient care.

So let's look at another example, go to Slide 34. And here we're looking at pulmonary disease so we're going to be talking about chronic obstructive pulmonary disease, chronic bronchitis and asthma. And again, we look at what are some of the types of concepts that we might want to capture in evaluating a patient; caused by, was it a chemical or environmental agents? There's a lot of agents out there like coal miner's disease and those types of things, the pneumoconiosis where specific chemicals, (asbestosis), other sorts of things where environmental agents may make a big difference in what caused this particular condition.

Smoking, what type of smoking, was it secondary, was it related to a dependence or environmental smoke? Was it related to some allergic or non-allergic type of factor?

And Slide 36 we might ask questions about temporal factors, was it acute, chronic, intermittent, was it persistent? Severity, things like asthma, we now capture in asthma whether it was mild or moderate or severe whereas we weren't capturing those things in ICD-9. They're important in patient care but they're now also needed in terms of coding properly.

Moving to Slide 37, bronchitis, looking specifically at bronchitis we would want to capture is it simple bronchitis? Is it mucopurulent? Is it associated with tracheitis or trachea bronchitis?

In Slide 38 we're looking specifically at things like emphysema, we want to capture what type, is it unilateral, pulmonary emphysema which can be described as a number of alternative terms below it. Is it panlobular emphysema? Is it centralubular emphysema or is it some other form of emphysema noted in 39, bonus emphysema,).

If we move to Slide 40 for other types of chronic obstructive pulmonary disease we might want to record things like was there acute lower respiratory infection and if so what was the infectious agent? Was there exacerbation of the chronic obstructive pulmonary disease? What are some of the other forms that we're looking at?

In Slide 41 specifically around asthma we may want to record things like what specific type of asthma was it? Was it associated with wheezing? Is it an exercise-induced pulmonary spasm? Is it a cough variant type asthma? Is it (atopic) type asthma?

In Slide 42, again, talking about some of the alternatives that might be used to describe asthma. Slide 43, again, just some of the other alternative terms that might be used in terms of asthma whether it's idiosyncratic, whether it's non-allergic. So all of these are concepts that may or may not be relevant to asthma but again if relevant we want to see them documented.

Similarly in slide 44, was it uncomplicated? Was it associated with acute exacerbation? Was it associated with status asthmaticus? Where appropriate those certainly should be documented.

So let's look at some of the codes that are associated with chronic obstructive pulmonary disease, bronchitis and asthma and see where those concepts come in. So here is a list of example codes related to those chronic pulmonary diseases. And we'll see J418 mixed simple and mucopurulent type chronic bronchitis.

J432, centralobular emphysema. J41, chronic obstructive pulmonary disease with acute exacerbation for asthma, severe, persistent, asthma with status asthmaticus. So those concepts that we're capturing all factor in to which code might be selected.

Now let's look at slide 46. So one of the things we want to be looking closely at is, are we using nonspecific codes? There's going to be a lot of emphasis on using codes that are specific to the particular condition.

And it's important that for proper coding, for proper data, to make sure that we've got the documentation needed to support that code going forward, that we have as specific codes as we can get. There are times when we can't get that specific but wherever possible we should.

So the challenge really is , what do we mean by specific code? So if we go to Slide 47, while you will often hear that we shouldn’t use unspecified codes, it's hard to describe what we mean by that. So what I've done here is tried to put together a definition of what we would consider a poorly specified code.

And this really is defined as coding that does not fully define important parameters of the patient condition that could otherwise be defined given the information available to the observer and the coder.

So if it's an important condition, a parameter of the patient condition, and given that the observer has access to the information the coder should code to the greatest level of specificity known. Now sometimes you just don't know that.

So in Slide 48, as we mentioned, sometimes unspecified really makes sense. If the patient is early in the course of evaluation, the patient comes in and presents and says they've got abdominal pain, they really don't have any other symptoms, they can't define it a whole lot better, can't even describe the location a lot better, you don't know exactly what's going on there but as part of the initial evaluation start ordering the appropriate tests and further evaluation.

So early on maybe all we know is that it's abdominal pain. If it's the third or fourth or the 10th visit and the diagnosis is still abdominal pain then we have to really wonder are we doing anything at that point in time? The diagnosis may change over time as we gather more information. If so, the coding should become more specific, relevant to those changes.

There also may be claims coming from providers who are not directly related to the patient's condition and may not be at a high level of specificity. There may be certain providers who really don't have that information or who don't even do diagnosis but they still have to submit a code. In that case non-specified codes may make a lot of sense.

And there are some types of coding that really are not appropriate for generalists. They may be more appropriate for a specialist. For generalists for example, he or she may not know that a patient with an acute open Maisonneuve fracture has a Gustilo Class 3 injury. They may not know all of those details but the specialist taking care of the patient should.

So the clinician who is seeing that as a generalist may code to a lower level of detail describing an open fracture of the tibia whereas the specialist might code to a much greater level of detail. So the use of specificity varies. The key is that we should always be coding to the level that's most specific given the knowledge of the patient and the level of the provider at that period of time.

If we go to Slide 5 there are a lot of codes that are out there right now in ICD-10 that really, we probably should never use or very rarely if ever. So any time we have sufficient information to be more accurate we shouldn't be using anything unspecified. There are some basic concepts that we should essentially never use unspecified.

So if you look at all of the codes relating to laterality you'll find ICD-9 codes that say right side, left side or side unspecified. Well, if we're going to treat a patient we ought to know what side it is. We ought to know whether it's right or left. We ought to know whether it's bilateral or unilateral. And really there's no reason to use an unspecified side.

For certain anatomical locations - if we're going to treat a patient we ought to know the anatomic location - we should know something more than a vague description like the right upper extremity. We ought to know where in the upper extremity and we ought to be able to define it. We ought to know if we're treating OB patients which trimester it is; what type of diabetes it is.

If there are complications or comorbidities we ought to be able to know and document those things, and certainly severity levels, acute or chronic. If you're treating a patient for respiratory failure we should never be using a code saying unspecified respiratory failure. We can't really treat the patient if we don't know whether it's acute or chronic or other key parameters.

So the idea is that if we're going to treat that patient there's a certain level of detail that we should know and the codes should really reflect that. There are sometimes, when in order to care for a patient, we need to have a lot of details.

And, again, if you're a specialist you ought to be able to define to a much greater level of detail.

So let's go to Slide 50. The bottom line about these codes is they really represent patient data about healthcare. And that patient data is used for a lot of purposes not only billing, it's used for analysis, it's used for policy setting, it's used for a whole variety of purposes in terms of trending and tracking and reporting.

The bottom line is, good patient data is important to good patient care. We really can't provide good care for patients if we don't understand what's going on with the data about that patient care. And to get good patient data requires three things. It just doesn't happen, it requires three things. It requires complete observation of all the objective and subjective facts relevant to that patient's condition.

It involves going back to what we were taught in medical school. When we see that patient with these conditions here are the things that we should be observing and recording. Secondly, it requires documenting those observations. If we looked in that patient's ear and they've got a perforated membrane and it's exudative and it's the right ear we ought to be documenting that.

The third is that given good documentation, should be coded properly. We pick the codes that represent as accurately as possible what's documented. So those three things, observation, documentation and coding are all critical or else our health data is really very unreliable moving forward.

So moving to Slide 51, getting to good quality data is something that's an ongoing effort. It requires that, again, we have proper assessment, complete documentation, accurate coding but we also need to constantly measure and provide feedback. Are we coding in a specified way? Is it accurate? We need to be measuring that so we can constantly feedback to clinicians and to coders to say here are some areas where we could potentially have some improvement.

Now moving forward let's move to Slide 52, we are moving into a very different environment under accountable care, under all the other things that are happening right now. The bottom line is that we spend more than anywhere else in the world and our ability to continue to spend at that level in terms of healthcare is definitely being challenged by a number of financial issues.

So the whole idea of value-based or accountable care or any of the other things that are out there right now are saying we need to do something to make sure that the services that we're providing are good, that they're effective and that we can afford them. And so that's changing the way we're looking at healthcare data, we're looking at transactions, we're looking at claims.

ICD-10 provides us an ability to look at severity and risk to a much greater level. It allows us to look at varying levels of complexity. Today if you have an amputation of the finger you can’t identify which finger it is in ICD-9. Under ICD-10 it tells you which finger, which level of and which approach.

If you look at a code for repair of an artery today it simply says repair of the artery; under ICD-10 it tells you which specific artery was repaired. So certainly these measure different things in terms of levels of severity and risk that we're comparing things that represent the actual condition in a much better way.

Better claim information can also help support more automated processing, hopefully lead to more rapid reimbursement given that we have more data within that code that will help address that processing.

There are opportunities to reduce audit risk exposure by making sure that the documentation and the coding are lined up appropriately. Better business intelligence and certainly much better measures of quality and efficiency.

None of this happens passively, we have to build that in to how we use and leverage these codes going forward. But the codes do present some opportunities to get a lot better data, not only to process and manage care, but also to understand and do analysis on the type of care.

To summarize, ICD-10 will certainly have a substantial impact on how we're going to define the patient condition for a wide variety of purposes. It isn't all about claims; it's about a lot of other uses for the data. It will certainly change how we do business.

There is a lot of that about how we're going to pay differently in an environment that looks at not only what was done but why. There are a number of proposed new changes that are going to be using these codes in a way that they haven't been used in the past.

The requirements for good documentation have really not changed. We should have always been documenting what's important in patient care. If you really look at what's needed under ICD-10 almost everything is something that is important in patient care if it applies to that patient. ICD-10 codes can certainly support much better definition of the key parameters of some of those conditions.

And Slide 54; complete and accurate documentation of important clinical concepts of the patient condition is a requirement for good patient care. It's also necessary for us to code accurately but most importantly it is a requirement for good patient care.

Better data translates into better understanding of efficiency, effectiveness and quality and changes in payment models will leverage these as we kind of move forward.

So all in all ICD-10 is a big change, it's a very important change in terms of healthcare data. It will impact almost everyone in healthcare. The bottom line is that good documentation will hopefully get us to better coding. And we should be able to do this without a substantial change in that documentation assuming that we're documenting well today.

So let me just stop there and ask if we have any questions to address.

Bill Finerfrock: Yolan, you want to give the instructions for folks who want to ask questions?

Coordinator: Certainly. At this time if you would like to ask a question please press star 1 on your touchtone phone. You will be prompted to record your name. And please unmute your phone and record your name clearly when prompted. Once again to ask a question, please press star 1.

Bill Finerfrock: While we're waiting, you talked about the issue of the non-specific codes. And I think this has been an area where there's been some significant discussion in the provider community. And maybe you don't have any perspective but it is largely going to be determined by the payer as to how specific they would require the coding to be with respect to whether or not they will pay the claim or send it back for additional documentation?

Joe Nichols: Right. Well certainly the payer determines what they're going to do with that claim from a payment perspective. In terms of what's required from coding that is not relevant to the payer. The level of specificity is designed - defined in the guidelines and in the standard. And regardless of payers rules audits will ask the question; did we code as accurately as possible what that patient's condition is?

Payers should be using that information and how they use that is really up to them. But from a provider perspective we should always be coding to the greatest level of specificity possible.

Bill Finerfrock: And that's really not changed from ICD-9 to ICD-10, correct?

Joe Nichols: Absolutely not. That's always been the case. We haven't been doing a great job of that in many instances but that's always been the case. And a lot of payers now are saying we're going to get a lot tighter on that now that we have that ability to be more specific we're actually going to not accept codes like unspecified side or unspecified respiratory failure.

Bill Finerfrock: Right. And I've heard the same thing. And it makes sense that they would do that. I mean, otherwise why go to ICD-10 if they're going to continue to allow claims to come in using unspecified. We're not getting all the more robust data that we would hope and yet we're going to an awful lot of expense to really not improve the data that we have.

Joe Nichols: Exactly.

Bill Finerfrock: So, Operator, do we have any calls lined up or questions?

Coordinator: I do. Our first question today is from Christina Hamilton.

Bill Finerfrock: Go ahead, Christina.

Christina Hamilton: Hi. I just had a question. These ICD-10 diagnosis codes are now going to require laterality. So do we still need to use the LTRT modifiers on the CPT codes?

Bill Finerfrock: Christina where are you from?

Christina Hamilton: Family and Internal Medicine, Lebanon, Kentucky.

Bill Finerfrock: Okay great. Thanks.

Joe Nichols: Yeah, that's a great question. We get that all the time. The modifiers on the service codes are still required. They don't have anything to do with ICD-10. Because you may have conditions where you have laterality but the service is to a specific side. And so the laterality on the service as what side you did that procedure on, the laterality on the code says what side the condition was.

They may seem like minor things but sometimes you can have a condition that is on one side or the other and the service is for a specific side. So, yes, they still are required on the CPT codes.

Bill Finerfrock: Good. Next question.

Coordinator: Our next question is from Karen Jones.

Bill Finerfrock: Karen, tell us where you're from.

Karen Jones: Hey, guys. We're from Marble Falls, Texas with the Scott and White Healthcare Organization.

Bill Finerfrock: Great.

Karen Jones: I have a question about the well woman exams or well child, all the V codes that we use currently. How does ICD-10 handle that? And at what level of specificity are we getting on those?

Joe Nichols: Yeah, good question. So the V codes that we're using for like EPSDT and other types of codes are codes that are called diagnosis codes, they really are more about encounters. Those codes will be available in ICD-10. And many of those codes are almost one to one in ICD-10. Often in ICD-10 you'll see a Z code used.

Now you have to be careful because a lot of the V codes translate to many other types of codes. But in general you're going to see a very similar thing in ICD-10 for those types of codes.

Karen Jones: Great. Thank you.

Bill Finerfrock: Okay.

Coordinator: And once again if you would like to ask a question please press star 1. And our next question is from Amy.

Bill Finerfrock: Amy, where are you from?

Amy: Bay City, Michigan.

Bill Finerfrock: Great. What's your question?

Amy: My question is how does the ICD-10 pertain to the MAs that work on the floor in the offices?

Bill Finerfrock: I had a little bit of difficulty, maybe you heard it, Dr. Nichols. Could you repeat your question again?

Amy: Yeah. How does the ICD-10 pertain to the medical assistants that work the floors in the offices? Because it seems like it's more for the billing.

Joe Nichols: Right so if we're looking at putting out the codes it's kind of a team effort to some degree. We're capturing information through a variety of sources. The bottom line is the clinician or whoever is the provider of record, is responsible for recording at the accuracy level that they can what the patient's condition is. And it's up to the front office to determine which code or the billing office to determine which code should be used for that.

So the MAs, for example, may play some role in pulling that information together but ultimately whoever is the responsible treating provider is responsible for the documentation and ultimately the coding done by the billing office.

Bill Finerfrock: Regarding that question, Dr. Nichols, back early on, in your slides, you talked about doing kind of an overall practice assessment or evaluation of who's going to need those codes or who's going to need that information.

Joe Nichols: Right.

Bill Finerfrock: And isn't that an area where this would kind of be teased out of who either is drawing information from the medical record or supplementing information. Obviously the providers should be putting the information into the medical record.

But one of the things that I've talked to folks about is even in their current environment is looking at your medical records and trying to code those medical records at an ICD-10 level to determine what information is missing from your documentation that will be necessary a year from now so you can begin talking to your providers about hey, you know, we've gotten a little bit lazy here, in the future we're going to need X, Y and Z and you're not consistently putting that into the medical record.

Joe Nichols: Right and that's a point, Bill, that, you know, each practice is going to be different, each specialty is going to be different. You do need to look at the codes that are relevant to you and go look at those codes and see what types of concepts are going to need to be captured.

And then there may be a variety of persons in the office who may have different roles. For example in my practice I had someone who actually did interviews with these patients to capture a lot of this information up front so that when I saw the patient I had a lot of this information in front of me.

Some of that new information you may want to capture up front because we're always going to need this in coding going forward. But understanding what the role of various folks are determines what level of understanding they need this.

And then as you mentioned, we need to make sure that if we are not capturing this information today and we know what information we need to capture for things like otitis or for pulmonary problems or headache, than we create prompts or assists or we educate around those types of things saying, you know, we really needed to say whether it was acute or chronic. So we need you to capture that.

Bill Finerfrock: Okay. Yolan, do we have other questions?

Coordinator: And one moment please for the next question. Our next question is...

Bill Finerfrock: We lost somebody or I did anyway.

Coordinator: I apologize. Our next question is from Missy.

Bill Finerfrock: Missy, go ahead. Tell us where you're from.

Missy: Hi. My name is Missy. I'm from Essexville, Michigan.

Bill Finerfrock: Okay. What's your question?

Missy: My question is, we are an offsite billing service relying on MAs and PAs to document the proper information for us to code and bill out the claims, and doesn't that start in the beginning when the patient enters the office and gives them their chief complaint and so forth?

Joe Nichols: Yeah, exactly. And that goes back to the - I talked about it - there's three things that we need to make sure that we get at the right data. First, they've got to do the evaluation and observe and capture the things they need to do. Second, it needs to be documented and only then can you do the coding.

So if you're doing coding and you're removed from that you're really very dependent on the folks that are doing those observations and capturing that information in order to get at the right code. You can't make that stuff up.

The only other option you have is to go back and query the source and say I need this information which side was it or was it acute or chronic. You know, those types of queries are going to have to occur because you're going to have to pick a code and you don't want to make that up.

Missy: And with that said, sir, again, that would start when the patient is in the office. Being that we're offsite it would require the biller, rather, to request office notes in order to properly process that claim, correct?

Joe Nichols: Correct, either that or you're going to end up using a very unspecified code, which is clearly not what we want to see happen. And, secondly, the payer may not accept it. So the bottom line is we've got to get people lined up to get better documentation so you can do your job better.

Bill Finerfrock: And I think that's going to be true whether it's an offsite billing company or whether it's somebody in an office. I mean, it all is what's going to be in that medical record, what's going to be in that chart, that someone then is going to look and convert that into proper coding.

I had a conversation recently with a doctor and I said, "How are you doing in terms of ICD-10 preparation?" And he said, "Oh I'm not worried about it, I'll just use a crosswalk." And can you talk to that a little bit that this notion that somehow there's a magical computer program that's going to allow the practice to automatically convert an ICD-9 to an ICD-10 code, that that just doesn't exist.

Joe Nichols: Right. No - and that's a great point, Bill, because a lot of folks have said oh we'll do something simple. I mean, we all want to believe in magic. We want to be able to do something and then suddenly the solution will be there. But it simply isn't the case.

We're talking about to many relationships between many ICD-9 codes, many ICD-10 codes where less than 5% of the codes will map accurately. If you look at all of the codes to see which ones you can map from one code to the next assuming you are trying to provide the same information that I intended less than 5% of the codes will do that accurately.

All the rest of the codes we're either going to assume something that may not be true or we're going to lose some substantial information in that crosswalk that we didn't want to lose as part of a cross walking. So I virtually never talk to providers about cross walking because providers should never crosswalk. You should be coding to the guidelines and the requirements that you code as accurately as possible what that patient's condition is.

You don't code based on how your old code cross walked to a new code because it could crosswalk to thousands of codes. And you've got to have the code that represents accurately what the patient's condition is. So I strongly recommend that no one consider using crosswalks for getting to their codes. It causes huge issues moving forward.

Bill Finerfrock: Okay. Yolan, do we have other questions?

Coordinator: I am showing no further questions at this time, sir.

Bill Finerfrock: Okay. I think we're right up on our 3 o'clock time. Dr. Nichols, did you have any last closing comments you wanted to make?

Joe Nichols: No, I just appreciate the opportunity to chat with you and some great questions. And hopefully this has been some help.

Bill Finerfrock: You know, I've got to tell you, I've done a lot of ICD-10 meetings and conference calls and programs and I thought this was very helpful, very educational. I'm neither a clinician nor a coder but I found it very educational and informative and I hope that those who were listening did as well.

And it was exactly what I think we need to see, some more of this level of detail and an opportunity for folks to have these conversations. Although we are, as you noted at the outset, a year out, that's really not a whole lot of time and there's a lot of work and a lot of education that needs to occur to make this go as smoothly and efficiently as possible.

So thank you.

Bill Finerfrock: I'd also like to thank everyone else for participating. I want to thank the folks from the Centers for Medicare and Medicaid Services for making Dr. Nichols available. It was extremely beneficial, and without their assistance, this would not have happened.

In the future I want to encourage all of you who may be interested to register. If you know others who would benefit from this technical assistance series we welcome their participation.

I do want to reiterate today's call was recorded and a transcript of the call and a recording will be available. I don't know how quickly we will have that up and posted. It will be available on the Federal Office of Rural Health Policy Website. Just so you know that Web address is www.hrsa.gov/ruralhealth /policy/confcall/index.html.

If you didn't get that or you need a link just send me an email at info@narhc.org and I will provide that to you.

Again, thank you, Dr. Nichols, for a great presentation, information.
We will get you information about our next Rural Health Clinic technical assistance call which will be some time either late October or early November.

Thanks, everyone, for participating, and we'll talk to you the next time.

Joe Nichols: Thank you.

Coordinator: Thank you. And this does conclude today's conference. You may disconnect at this time.

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