



ICD-10 COMPLIANCE

Process Improvement and Maintenance for Long-Term Care

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ICD-10 Compliance: Process Improvement and Maintenance for Long-Term Care is published by HCPro, a division of BLR.

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ISBN: 978-1-55645-478-3

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Part I

CHAPTER 1

Introduction to ICD

For the past 30 years or so, the medical community in the United States has used International Classification of Diseases, 9th Edition (ICD-9). This is the system of diagnosis codes used in medical claims and to communicate the patient's condition to all providers and payers. Since its implementation in 1979, ICD-9-CM has been the most important code set in the medical billing and coding field. In the past 10 years, medical coding is one of the fastest growing fields for new jobs, and with the transition to ICD-10, that demand will grow further.

As of late, the ICD-9 system is not only outdated but insufficient in properly diagnosing a patient's condition. More detailed information will be included under ICD-10, such as anatomical location, whether the site is on the right or left side of the body, and many other useful options. Most of the rest of the world is already using ICD-10, and some countries have been using it since as far back as 1995. More detailed information will be included under ICD-10, such as anatomical location, whether the site is on the right or left side of the body, and many other useful options.

The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA) and all providers regardless of the healthcare setting. In addition, all payers and vendors, including clearinghouses that process claims on behalf of providers, will also be required to transition to this new system.

There are two different and distinct types of coding sets under ICD-10: ICD-10-PCS for the inpatient setting and ICD-10-CM for the outpatient setting, which includes skilled nursing facilities (SNF). One important note is that other coding required for SNFs will not be changing at this time; all HCPCS and CPT codes, used mainly in Medicare Part B billing, will remain the same and will continue to be used. SNFs should be aware that, although HCPCS and CPT codes will not be affected, the assignment of the principal medical diagnosis for which services are being provided will need to be reported as an ICD-10 code.

Why ICD-10?

The ICD is used to standardize codes for medical conditions and procedures. Although most countries already use the 10th revision of these codes (ICD-10), the United States has yet to adopt this convention. The Centers for Medicare & Medicaid Services (CMS) is working closely with all industry stakeholders to provide support in transitioning to ICD-10 on October 1, 2015. Reasons to move to ICD-10 include:

- ICD was developed to reflect care and services being provided to patients. It collects uniform data for research and education on disease patterns and causes of death.
- ICD-9 produces limited data about patient's medical conditions and hospital inpatient procedures.
- ICD-9 limits the number of new codes that can be developed. Many ICD-9 categories are already full.
- ICD-10 will be much more specific than the codes we are used to under ICD-9. It will contain more than 68,000 codes, compared to the 14,025 we currently have under ICD-9.

ICD-9 is outdated

ICD-9 is more than 35 years old and contains outdated, obsolete terms that are inconsistent with current medical practice. The structure of ICD-9 limits the number of new codes that can be created, and many ICD-9 categories are full. ICD-10 provides room for code expansion, so providers can use codes more specific to patient diagnoses. The United States is the last major industrialized nation to make the switch to ICD-10.

ICD-10 codes will provide better support for patient care and improve management, quality measurement, and analytics.

Since ICD-10 codes are more specific than ICD-9 codes, doctors can capture much more information, meaning they can better understand important details about the patient's health than with ICD-9-CM. This will:

- Improve coordination of a patient's care across providers over time
- Advance public health research, public health surveillance, and emergency response through detection of disease outbreaks and adverse drug events
- Support innovative payment models that drive quality of care
- Enhance fraud detection efforts

The reason ICD-10 contains so many additional codes is simple—specificity. ICD-10 allows you to use a single code to report both a disease and the current manifestation of that disease. This same system applies to injuries. For example, ICD-10 includes separate codes for an initial bone fracture, a follow-up

appointment showing the fracture healing normally, a follow-up appointment showing the fracture in nonunion, and a follow-up appointment showing the later effects of the fracture.

In 2008, the U.S. Department of Health and Human Services (HHS) issued a proposed rule to transition to ICD-10 on October 1, 2011. Stakeholders commented that they needed additional time to prepare for the transition. In the 2009 final rule, HHS established October 1, 2013, as the date for the transition to give providers two additional years to prepare.

In 2012, as part of President Obama's commitment to reducing regulatory burden, HHS moved the ICD-10 compliance date to October 1, 2014, providing the industry with an additional year to work toward a successful transition. The Protecting Access to Medicare Act of 2014 (PAMA), which was enacted on April 1, 2014, prohibited the secretary from adopting ICD-10 prior to October 1, 2015.

CMS held transition preparedness calls in early 2013, and discussions found high awareness of the ICD-10 transition among providers, payers, and vendors. But readiness and awareness of the October 1, 2015, compliance date varied. Participants noted the importance of communication between vendors and providers, in particular. Some providers in small, independent practices say that they will prepare for ICD-10 when their vendors tell them to do so. Yet many have not heard from their vendors. CMS is working with vendors and providers to promote the dialog needed for a successful transition. All three groups expressed confidence that they would meet the compliance deadlines, although many of those interviewed could not recall the deadlines. Both vendors and payers expressed concerns about provider readiness. Vendors were also concerned about payer preparedness.

Results of the CMS ICD-10 preparation calls revealed many providers are not fully prepared nor are they planning for the full impact of the transition:

- Most providers have begun preparing for ICD-10, but only one had secured an implementation budget
- About one-half of providers have talked with a software vendor/developer about version 5010, while the other half have not begun to prepare
- Overall self-reported preparedness levels were:
 - Highest among vendors
 - Lowest among providers

Reported concerns:

- Vendors—ability of payers and providers to transition on time
- Payers—providers' learning curve
- Providers—time and cost associated with learning the new codes

When assessing the preparedness of your vendors, some topics to discuss are outlined as follows. These are not meant to be all inclusive:

- General awareness of transition
- Knowledge of transition deadlines
- Steps organization has taken to prepare
- Expectations about meeting deadlines
- Barriers to compliance
- Timing of specific action steps to prepare

Providers should ask specific questions regarding the last bullet. A definitive timetable should be established with implementation schedules, goals, and deadlines. These schedules, goals, and deadlines should be shared with all entities involved in the transition and planning within your organization. This will allow facilities to, in turn, develop their own specific timetable for implementation for each level of the transition.

CMS will release final decisions regarding the implementation of ICD-10 and the transition to the new system, as it does each year regarding other regulation changes. Table 1.1 shows the anticipated timeline.

Table 1.1 | Anticipated Timeline for Implementation of ICD-10

Rulemaking phase	Approximate time frame
Proposed rule development	Fall/winter
Proposed rule publication	Late spring (April/May)
Comment period	Late spring/early summer
Final rule publication	On or about August 1, 2015
Final rule effective date	October 1, 2015

In addition to the initial conversion, there will be updates to the ICD-10 item sets, as well as claims processing changes that may affect payment processing.

For a given fiscal year, the quarterly release schedule includes standard systems and claims processing specifications, including ICD codes, as follows:

- First quarterly release—On or about October 1
- Second quarterly release—On or about January 1
- Third quarterly release—On or about April 1
- Fourth quarterly release—On or about July 1

Benefits of Implementing the ICD-10 Coding System

ICD-10 implementation is a complex process that will take organizationwide planning and preparation. It will require the ability to leverage the investment from compliance to an actual strategic advantage. Provider engagement and early preparation will be the key to a smooth transition and earlier realization of the benefits of ICD-10. Those benefits include:

- Increased ability to measure patient quality and safety
- Increased usefulness of the electronic health record (EHR)
- Increased billing and reimbursement systems
- More reliable input for reimbursement methodologies
- Accurate information for resource management and labor costs

Stopping or delaying the ICD-10 transition date would be costly to providers and all healthcare sectors

The industry has invested significant resources toward the implementation of ICD-10. Many providers, including physicians, hospitals, and health plans, have already completed the necessary system changes to transition to ICD-10. Additional delays pose significant costs for providers who have updated their system.

CMS and many commercial health plans are unable to process claims for both ICD-9 and ICD-10 codes submitted for the same dates of service, so a “transition period,” in which providers could submit claims using either ICD-9 or ICD-10, is not possible.

At the same time, it is not feasible to skip directly to ICD-11, because ICD-10 is a foundational building block prior to moving to ICD-11. The earliest the ICD-11 code set will be released by the World Health Organization (WHO) is 2017. Several prominent industry groups, including the American Medical Association, have issued statements opposing transitioning directly to ICD-11 because of the complexity of the coding system and the best practice to implement ICD-10 to gain experience with that system first.

CMS has conducted extensive ICD-10 outreach, education, and testing

Not only will facility-level changes need to be made, but Medicare online billing systems will need to update their processes as well. Each Medicare Administrative Contractor (MAC) will make changes to allow ICD-10 codes to be accepted. Some of these areas may affect SNF providers and should be discussed during the facility ICD-10 transition strategic planning meetings.

The Centers for Medicare Management (CMM) components develop and implement a new payment policy based on federal mandate, CMS initiative, or cost savings, which may include ICD codes that impact the standard system specifications.

The Provider Billing Group (PBG) communicates the required operational changes that are developed based on the needs of the policy updates via the Change Request Management Process by publishing a change request for implementation. The Fiscal Intermediary Standard System (FISS) interfaces/interacts with other CMS software applications and editors, such as Medicare Severity Diagnosis-Related Groups (MS-DRG), code editors, pricers, and fee schedules. Not all the applications contain ICD codes. For example, the fee schedules do not contain ICD codes, but they interact with other components of the billing system. Although HCPCS and/or CPT codes will not be affected, outpatient billing will, due to the fact that a medical diagnosis is utilized to support why services were rendered and identifies the condition requiring treatment or consultation.

The following FISS online screens have been identified to contain ICD diagnosis/procedure codes and will be required to change for ICD-10. SNFs should consider whether these additional screens are utilized within the organization and develop processes to address the transition to ICD-10. This includes collection of information regarding diagnoses and accuracy of the codes used. Inadequate preparation of claims or requests for coverage limitations may result in inaccuracies being reported and potentially denied payments:

- Medicare secondary payer (MSP) insurer
- End-stage renal disease (ESRD) remarks
- CWF attachment
- Therapy attachment
- Plan of care attachment
- Roster bill
- Medical policy
- ICD
- Limit of liability
- Mass adjustment selection
- Expert claims processing system (ECPS)
- Claim inquiry screen

The following direct data entry (DDE) online screens used by SNFs have also been identified to contain ICD diagnosis/procedure codes and will be required to change for ICD-10:

- ICD diagnosis/procedure code inquiry
- Therapy attachment

In addition to directly billing Medicare Part A or Part B, there are situations when SNF providers are billing another payer initially, and Medicare is the secondary payer. Those claims must also be correctly converted to ICD-10 in order to receive due payments. CMS has investigated where vulnerabilities may exist within this secondary billing system.

Part A and B crossover utilization is when the host receives a Part A bill; the Common Working File (CWF) automatically checks the information in the record against the beneficiary's history files for both Part A and Part B utilization. If there is a conflict (or "crossover") of services, CWF will generate an A/B crossover error code. In addition, the MSP process objectives are identification of beneficiaries' claims that CMS may have erroneously paid as the primary insurer and recovery of funds mistakenly paid by CMS. The MSP process is primarily a postpayment activity, but it also features a prepayment process with front-end edits that are generated in the presence of MSP auxiliary records at CWF.

Another area for SNF providers to consider is the systems utilized for probe reviews for medical record requests for more information. This includes the prepayment medical review process, which is the action of the medical review staff that performs either a routine or complex review of a nonadjudicated claim. These may be requested before or after payment has been received by the MAC. If a review is requested after payment has been made, it is considered part of the postpayment medical review process. SNF contractors are required to make changes to their business processes and systems to accommodate the new ICD-10 codes. Prior to ICD-10 implementation, policy areas will work to create CMS change requests (CR) with the necessary policy modifications with provider billing group (PBG) and other CMS components to ensure a judicious implementation to ICD-10. Due to the high volume of required changes and the fact that these changes impact the claims processing process, there is a high impact if the CR specifications, edits, and modifications are not done accurately, efficiently, and in a timely manner. The following list of SNF payment policy areas will require updates.

- Resource utilization groups: The SNF prospective payment system (PPS) incorporates adjustments to account for facility case mix, using the system for classifying residents based on resource utilization known as RUG-IV. Facilities will utilize information from the most recent version of the Minimum Data Set (MDS) to classify residents into the 66 RUG-IV groups. The RUG-IV grouper software program is used by providers to assign patients to an appropriate group based on the MDS 3.0 and is available from many software vendors or the CMS Internet website. The MDS contains a core set of screening, clinical, and functional status elements, including common definitions and coding categories that form the basis of a comprehensive assessment. The assessments are required by law and are to be performed based on a predetermined schedule for the purposes of Medicare payment. For Medicare billing purposes, there is a non-ICD payment code (HIPPS) associated with each of the 66 RUG-IV groups, which is applied by the provider on the claim that is active in the SNF pricer software. In addition, there is an ICD-9/10 code associated with the AIDS add-on payment applied by the SNF pricer software.
- jRAVEN: jRAVEN uses a database of ICD-9/10-CM codes for reference in assisting users with the entry of ICD-9/10-CM codes into MDS 3.0 assessments.

CMS has developed multiple tools and resources that are available on the ICD-10 website (www.cms.gov/ICD10), including ICD-10 implementation guides, tools for small and rural providers, and general equivalency mappings (ICD-9 to ICD-10 crosswalk). These tools are included in Part II of this book for your convenience.

CMS has completed rigorous and comprehensive internal testing to ensure that CMS systems can accept and pay provider claims with ICD-10 codes on October 1, 2015.

CMS has also been conducting external testing with Medicare fee-for-service providers, including two successful acknowledgment testing weeks in March and November 2014, as well as February 2015. Providers that participated in the testing received electronic acknowledgment confirming whether the submitted test claims were accepted or rejected. While providers, suppliers, billing companies, and clearinghouses can participate in acknowledgment testing at any time, CMS will be conducting the next two special acknowledgment testing periods in March and June 2015 to highlight the testing.

Separately, CMS is offering three end-to-end testing weeks for a sample of volunteer Medicare fee-for-service providers and suppliers leading up to October 1, 2015. The testing weeks (January 26 to February 3, April 27 to May 1, and July 27 to 31) allow selected providers and suppliers to submit test claims to CMS with ICD-10 codes and receive a remittance advice explaining how the claims were processed. CMS is also working with state Medicaid agencies to conduct end-to-end testing.

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Is your long-term care facility prepared to implement ICD-10 coding? Between the additional specificity required for code selection and the substantial increase in the number of codes, developing efficient processes is imperative to managing the increased workload.

Train your staff now to ensure that effective and compliant processes are in place with *ICD-10 Compliance: Process Improvement and Maintenance for Long-Term Care*. This book focuses on process improvement before and after the ICD-10 coding implementation date. It highlights areas facilities can improve, including collaborating with physicians on documentation accuracy, working with vendors, analyzing revenue risks, claim reviews, and audits. This book will help facilities continually monitor their processes to ensure everything is running smoothly.

This resource provides:

- Various examples of effective processes that SNFs can integrate, including specific rationale behind each option
- Explanations on what could potentially prevent payments
- Guidance on how to ensure physician documentation accommodates ICD-10 coding
- Education on how to code new encounters
- Dual-coding examples
- Direction on how to untangle vendor issues to protect SNF Medicare dollars

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ISBN-13: 978-1-55645-478-3



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