

RADAR ICD-10 Workgroup



ICD-10 Coding System to Define Patient HealthCare

- ICD-10 is an upgraded diagnostic and procedural medical coding system, that will soon be mandated by the Federal government for use in the healthcare industry in insurance processing, reimbursement, and statistical data gathering.
- Final Rule Published January 16, 2008
- Compliance Date **October 1, 2013**
- Claims will not be accepted with ICD-9 codes after the compliance date



Why does coding system need transition from ICD-9 to ICD-10?

- ICD-9 Is running out of code sets
- ICD-10-CM and -PCS offer greater detail
- ICD-9-CM's terminology and classification of numerous conditions and procedures are outdated, vague, or inconsistent.
- The greater detail contained with ICD-10 will allow for a better understanding of chronic conditions of patients
- Providers and payers can expect a reduced need for supporting documentation under ICD-10. The lack of sufficient detail in current code assignments has led to increased requirements for documentation to support claims. ICD-10-CM and -PCS codes are expected to reduce that need.



Prepare and Plan

- Coding/billing
- Quality Assurance
- Utilization Review
- Compliance Staff
- Information Systems
- Outside Vendors

Success Factors

- Early Planning
- Leadership Support
- Careful Project Management

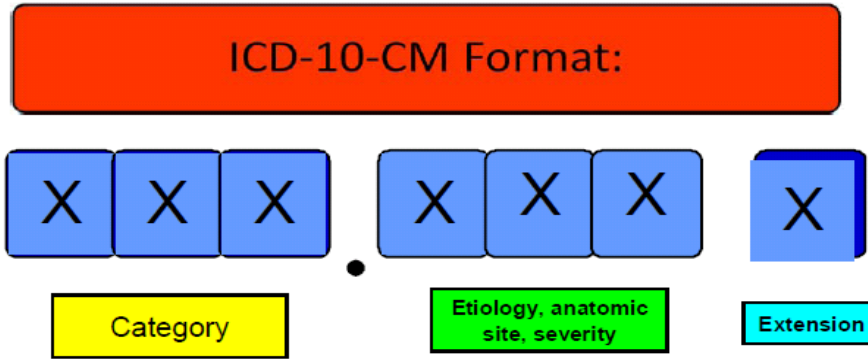
Major Differences



ICD 9 CM Diagnosis Codes	ICD 10 CM Diagnosis Codes
13,000 diagnosis codes	68,000 diagnosis codes
Uses 3 to 5 digit codes	Uses 3 to 7 codes
Chapters 1-17 uses all numeric characters, supplemental chapters use an alpha first digit (E or V)	<ul style="list-style-type: none">•Digit 1 is alpha (A-Z, not case sensitive)•Digit 2 and 3 are numeric•Digits 4-7 are alpha or numeric

ICD 9 CM Procedure Codes	ICD 10 PCS Codes
11,000 procedure codes	87,000 procedure codes
Uses 3 to 4 digit codes	Uses 7 digit codes
All four digits are numeric	Any of the digits can be alpha numeric. Letters O and I are not used to avoid confusion with numbers 0 and 1.

ICD-10 CM Format



Standard Meaning of 7 characters (Medical and Surgical Section)

- 1 = section
- [?] 2 = body system
- [?] 3 = root operation
- [?] 4 = body part
- [?] 5 = approach
- [?] 6 = device
- [?] 7 = qualifier



Advantages of Adopting ICD-10 CM and ICD-10 PCS

- Quality and outcomes measurement
- Medical error reduction
- Health policy planning
- Pay-for-performance programs
- Refinements of DRG systems
- Claim processing
- Public health monitoring
- Research



ICD-10 Workgroup

- Meets the 1st Friday of the month
- Informing industry of the massive changes to the existing coding system, and encourage industry to start preparing now.
- Informing industry on the impacts of the coding changes to medical coders, healthcare staff, physicians, software systems, documentation, and information technology.
- Providing resources and timelines for finding information and training sources.



ICD-10 Workgroup Resource List

- **AAPC**

<http://www.aapc.com/ICD-10/index.aspx>

- **AHA: ICD -10**

<http://www.ahacentraloffice.org/ahacentraloffice/html/icd10.html>

- **AHIMA: ICD-10**

<http://www.ahima.org/icd10/>

- **CMS**

http://www.cms.hhs.gov/ICD10/01_Overview.asp#TopOfPage

- **HCPPro's ICD-10 Blog**

<http://blogs.hcpro.com/icd-10/>

- **National Center for Health Statistics (NCHS)**

<http://www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm>

- **World Health Organization's (WHO's) ICD-10 Homepage**

<http://www.who.int/classifications/icd/en/>

Glossary

- ICD-10-CM International Classification of Diseases, 10th Revision, Clinical Modification
- ICD-10-PCS International Classification of Diseases, 10th Revision, Procedure Coding System
- CMS Centers for Medicare and Medicaid Services
- AHIMA American Health Information Management Association
- HHS United States Department of Health & Human Services
- WHO-FIC World Health Organization Family of International Classifications
- IFHRO International Federation of Health Records Organizations
- HFMA Healthcare Financial Management Association
- AHA American Hospital Association
- AMA American Medical Association



Documents available on the ICE Website

- Resource List
- Timeline for implementation
- Physician Fact sheet

Questions ?

Mechelle Reed, Brand New Day Healthplan
Email: mreed@universalcare.com



HCC Prospective Approach

- Key components for HCC Best Practice Implementation
 - Dedicated HCC Team
 - Administrative Support and Physician Champion
 - Certified Professional Coders
 - Call & Schedule Program
 - Practitioner Continuing Education
 - Staff Involvement in Team Approach
 - Annual HCC Assessment Program
 - Prospective Audits Prior To Bill Submission
 - Data Submission and Verification from CMS

DEDICATED HCC TEAM

- Establish a multidisciplinary team dedicated to HCC
- Coordination and planning of HCC activities becomes the responsibility of the team
- Reporting of monthly/yearly progress to administration regarding the HCC impact is valued
- Positive aspects of the HCC Program as well as where improvements are needed are evaluated
- Flexibility is maintained for adjustments in the HCC program as processes change: ex paper chart to EMR



Administration Support & Physician Champion

- Administrative Support for HCC is crucial in the success for any system wide program established
- Administrative Support includes financial support of staff positions necessary to implement a program
- Medical Group acceptance and knowledge of the importance of the HCC program
- A dedicated Physician Champion that can act as a leader within the medical group for HCC
- Attendance at Medical Administrative Meetings by HCC Team members for effective communication



Certified Professional Coders

- Certified Professional Coders are key to the auditing and educational programs for HCC
- The National Accreditation provides the necessary credentials for the auditing piece with HCC
- Certified Professional Coders are able to interpret documentation necessary to support HCC codes reported.
- Certified Professional Coders are able to add codes supported by documentation, as well as down code for compliance purposes.



Call & Schedule Program

- Medical Assistant/Scheduler dedicated to HCC Call & Schedule Program
- Scheduler manages risk-adjusted patient populations according to categories reported, RAF Scores etc.
- Edits Practitioner Schedules for HCC patient visits.
- Call & Schedules Patient visits for HCC Assessment
- Maintains a Master Excel/Access Spreadsheet for all activities regarding calls, edits, no-shows, appointments
- Communicates readily with practitioners and the HCC coding team regarding upcoming patient visits



Practitioner Continual Education

- Formal power point presentations to practitioners regarding the HCC model/risk adjustment coding
- Monthly HCC Newsletters on risk-adjustment coding
- Laminated Desk References and EMR HCC Enhancements for risk adjustment capture
- Drop-down reference listing of HCC codes in EMR/Paper Charge
- Weekly HCC Coding Tips E-mails
- HCC Coding Team E-mail Address for Questions by practitioners
- Print-Screen copy of practitioner documentation e-mailed to practitioner with HCC educational information
- Topic Focused HCC power point presentations: ex Diabetic Coding
- Background HCC information prior to patient visits sent to practitioners



Staff Involvement for Team Approach

- Actively involve all office staff in the HCC Program
- Forward communications to office staff on all HCC information to encourage participation
- Provide educational in-services on the basics of HCC
- Teach staff to recognize HCC patient appointments, prepping charts prior to assessment or informing practitioners on electronic record.
- Congratulate the staff team on accomplishments regarding HCC shared by the entire office
- Keep all staff updated on the statistics regarding HCC



Annual HCC Assessment Program

- Focus practitioner education on the importance of Annual HCC Assessments
- Incentivize the yearly assessment process for chronic illness evaluation
- Track Annual HCC Assessments per practitioner/per patient/per month for statistical reporting purposes.
- Congratulate practitioners on accomplishments regarding correct documentation and reporting of chronic conditions
- Send monthly updates on the progress of the Annual HCC Assessment program



Prospective Audit Prior To Submission To Billing

- Utilize a tracking code for review of Annual HCC Assessments and/or all HCC patient visits
- Forward practitioner documentation and code charge tickets to certified HCC coders prior to billing
- Certified Coders add HCC codes to charge encounter supported by practitioner documentation
- Certified Coders remove HCC codes from charge encounter not supported by documentation
- Educational e-mails sent to practitioners regarding coding changes for improvement on future visits
- Excel/Access spreadsheet of assessments reviewed maintained by certified coders for administrative reports
- Problem lists updated on patients charts by certified coders



Data Submission and Verification from CMS

- Utilize HealthPlan data base websites for patient data information
- Utilize companies that provide database handling of all HCC patient information for your population including accepted codes from CMS
- Run reports on patients not seen, high to low RAF scores per year, PCP RAF Performance, Medical Group performance.
- Utilize direct submission templates to HealthPlans for dropped HCC's and/or timely efficient data submission versus billing cycle to clearinghouse lag

Conclusion

- Have a dedicated HCC Team Approach
- Provide Continual Education and Communication Regarding HCC for practitioners and staff
- Know your population of HCC patients and maintain a “Call & Schedule” program
- Keep statistical records regarding HCC Assessment Visits
- Include all office staff in to team approach for HCC capture and success
- Make sure your practitioner documentation supports codes reported. Work to keep your charts audit successful.
- Track all HCC codes submitted to CMS / and correct any error reports on transmissions not accepted. Sometimes a very simple correction (digit on a code/ DOS) is worth high risk adjustment!!



The End

Barbara Johansen CPC

RADAR Physician Education Work Group



- **Mission:** The mission of the Risk Adjustment Data Acquisition and Reporting (RADAR) Physician Education Work Group is to provide coding and documentation tools and educational material relating to Medicare Risk Adjustment to the medical provider community. The RADAR Physician Education Work Group fosters excellence by working collaboratively with individuals from many areas of expertise to deliver professionalism and experience. By using innovative techniques to enhance continued learning we strive to provide each physician with the information needed to improve the quality of documentation in the medical record.



Resources on the ICE Website

- Documents that will be available on ICE website
 - Coding Hints handout
 - Download from the Ice Website for PCP's
 - Case Scenarios
 - Download from the Ice Website for all providers
 - Documentation Hints handout
 - Download from the Ice Website for all providers

Coding Hints

- Covering Basics such as:
 - Chronic versus acute conditions
 - Stages of chronic kidney disease / GFR
 - Conditions that require 2 codes
 - Strokes and heart attacks
 - Diabetes and related conditions
 - Mental health and addictions
 - Malnutrition

Case scenarios

- Actual cases (although not word for word) and their diagnosis code
 - Will show right and wrong way to code
 - Will show risk adjusted payment

Documentation Hints

- Basic such as:
 - Chronic conditions
 - Descriptive words such as major, chronic, history
 - Diabetes and related conditions
 - Conditions that need 2 codes
- Medical record requirements
 - DOS, name, signature, etc.
- Office staff directives



Other Resources

- Webinar for physicians
 - Will be complete and available in early Spring
 - Possible CME credit
 - May have the medical groups give incentives for their own physicians
- May have additional resources in the future such as:
 - Advanced coding handout
 - Other scenarios with coding



Questions ?

- Kathi Wylie
- kwylie@mhipa.com
- 562 981-9500 x 2285



Do You Want to Become a Medical Coder?

ICE does not endorse either of these organizations.
This is for informational purposes only.

There are 2 agencies that certify medical coders

- American Health Information Management Association (AHIMA.org)
- American Association of Professional Coders (AAPC.com)



AHIMA – American Health Information Management Association

- Coder Certificates offered:
 - Certified Coding Associate (CCA)
 - Certified Coding Specialist (CCS)
 - Certified Coding Specialist physician based (CCS-P)

AAPC – American Association of Professional Coders

- Certificates offered
 - Certified Professional Coder (CPC)
 - Certified Professional Coder –Hospital (CPC-H)
 - Certified Professional Coder –Payor (CPC-P)
 - Certified Professional Coder –Apprentice (CPC-A)
 - 19 specialty certifications



Examination Fees

- AHIMA examination
 - CCA \$205 members \$260 non-members
 - CCS \$320 members \$405 non-members
 - CCS-P \$320 members \$405 non-members
 - Membership \$165.

- AAPC
 - CPC, CPC-H, CPC-P \$300.
 - Membership \$120.



- Both offer
 - Study exams and materials
 - Classes
 - Monthly publications

- For more info go to their website
 - AHIMA.org
 - AAPC.com



Any questions?



Documentation Appropriateness as a Qualifier for HCC Incentives

Sue Erickson, HCC Programs Director
HealthCare Partners, California



Who is HealthCare Partners?

Southern California Division

- Predecessor groups founded in late 1970s
- Top 20% of physician groups in CA five years in a row by the Integrated Healthcare Association (IHA)
- Serving 500,000+ members with 85,000+ seniors
- Los Angeles Metro
- 4,500+ Contracted and Employed Physicians



HCC Incentive Plans Beneficiaries

- Employed and Contracted PCPs and Specialists
- Support Staff of the above



HCC Incentive Plan Drivers

- Risk Adjustment Factor (RAF)
- HCC Capture
- Chronic Recapture - Year over Year
- Use of Physician Portal Patient Reports
- Senior Wellness Visits

Documentation Qualifier





How to Measure

- Review of Random sample of 30-60 HCC ICD-9 codes per year drives Pass Rate
- Every two months for employed physicians
- Every six months for contracted physicians



Other Features

- Physicians under target receive 1:1 coaching from Certified Professional Coder (CPC) and HCC expert physician
- Target rises every year
- More strenuous than CMS Risk Adjustment Data Validation (RADV)—codes stand alone

Results

- Marked improvement in physician's documentation understanding
- Within 1 year, 83% of employed physicians above target.
- Within 2 years, 90% of employed physicians above target.
- 58% of contracted physicians with > 100 seniors above target after 1 coaching session.



Next Steps

- Complete Specialist review and perform coaching
- Continue to coach contracted PCPs
- Implement Electronic Medical Record (EMR) front-end audits = 100% pass rate

Learnings

- Training only required few times when
 - Incentives tied to pass rates
 - Highest pass rates maximize incentive (tiering)
- Frequent feedback = faster improvement
- EMRs don't always support appropriate documentation

Questions?



RADV Audit Prep Simplification



- Mission Statement: To facilitate the collaborative development of efficient tools and processes for health plans and providers in conjunction with a CMS RADV audit

RADV Audit Prep Simplification



- Deliverables to include:
 - Standardized request forms
 - Contact information for key individuals and/or departments who are responsible for collecting Medical Records requested by CMS
 - Health Plans
 - Providers

What is Simplification Anyway?

- Simplify -
 - Definition: to make something less complicated or easier to understand



Stages of a Risk Adjustment Data Validation Audit

1. Sampling and Medical Record Request
2. Medical Record Review (MRR)
3. MRR Findings and Contract-level Payment Adjustments
4. Documentation Dispute
5. Post Documentation Dispute Payment Adjustments
6. Appeals

Sampling & Medical Record Request Time Line



Responsible Party	Action	Timeline	Total Elapsed Time
Health Plan	Reply to initial request	5 days	N/A
Health Plan	Send Medical Record Request to Provider (Medical Group/IPA)	5 working days	1 wk
Provider	Send Medical Record to Health Plan	15 to 30 days	4 to 7 wks
Health Plan	Forward appropriate information to CMS	5 to 8 weeks	12 wks



Standardized Request Forms

- General Components of Request
 - State reason you need information
 - Identify collection period under review
 - Note if vendor is involved
 - HIPAA Concerns
- Include CMS instructions with specific member information under review

RADV



Medical Record Request Contact

Dear ICE Participant,

The ICE - Risk Adjustment Data Acquisition and Reporting (RADAR) Team has initiated RADV Audit Simplification Subgroup.

One of the group's objectives is to compile a comprehensive contact listing to make available to Health Plans and Providers in the event of RADV audit. This is in an effort to expedite the process as CMS only allows 12 weeks from initial notification to Health Plan to deadline for receipt of all requested medical records.

Whether you are a Health Plan or Provider, please identify the primary and secondary contact in the event Medical Records are needed for a Risk Adjustment Data Validation Audit (RADV).

The specific data is requested for both a primary and backup contact:

State	PCP_Group Name	Contact Name	Address	City	State	Zip Code	Email Address	Phone Number	# provided by contact
-------	----------------	--------------	---------	------	-------	----------	---------------	--------------	-----------------------



The Beginning

Pam Klugman

V.P. & COO - CVInfosys