The Most Sweeping Changes & Errors in Cardiology

INDIANA CHAPTER ACC
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2009-2010 What Happened To Cardiology Reimbursement?

"Would you please elaborate on 'then something bad happened'?"

What Happened To The 1.1% Increase We Had in 2009?

- CY 2008 Conversion Factor - **$38.0870**
- CY 2009 CF Update - 1.1 percent (1.011)
- CY 2009 CF BNA - 0.08 percent (1.0008)
- 5-yr review BNA - -6.41 percent (0.9359)

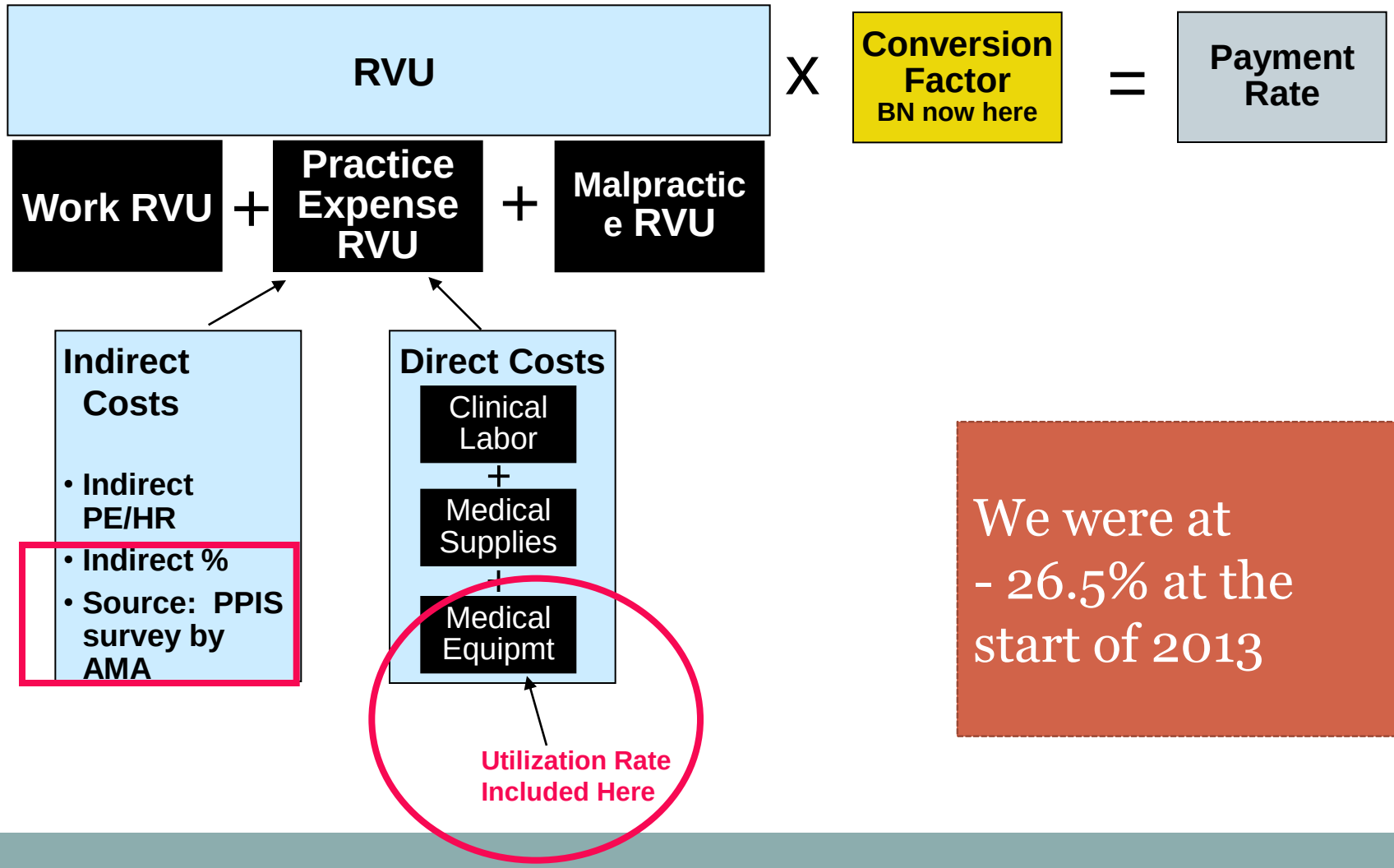
- CY 2009 Conversion Factor - **$36.0666**

- We actually saw a -13% decrease for cardiology …. And 2010 another -10%

What's Next ?


INSIDE THIS WEEK: A 14-PAGE SPECIAL REPORT ON AGEING
The Economist
Iran's agony
The mystery of Mrs Merkel
Asia's consumers to the rescue?
The Greeks and those marbles
Evolution and depression
Economist.com
Reforming health care
This is going to hurt

Why Is This A Mess?

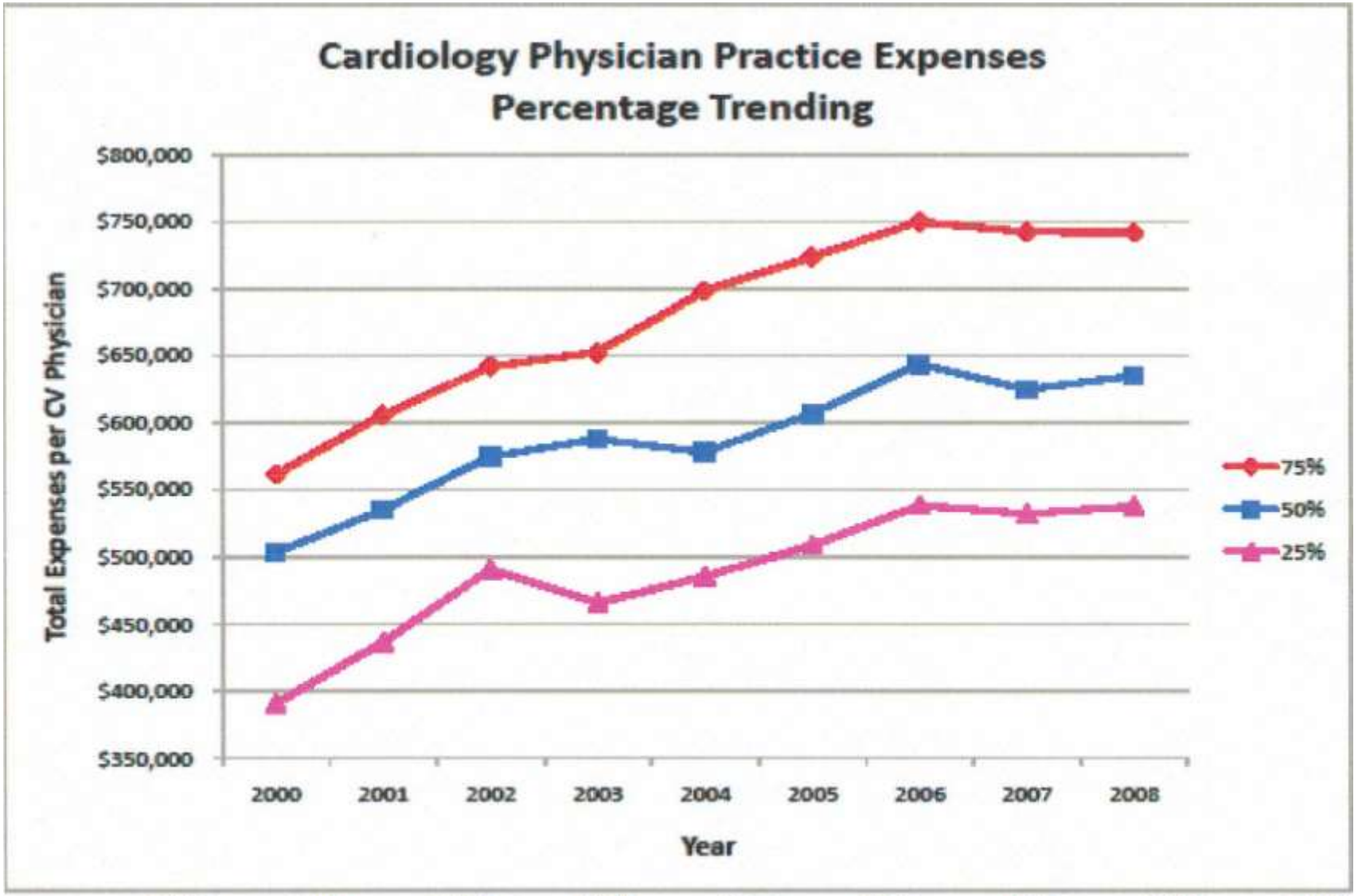


We were at
- 26.5% at the start of 2013

Practice Expense – the KEY issue

- Not the 1st look at PE (remember bottom up)
- Survey commissioned by the AMA
  - Physician Practice Information Survey
  - Needed 2 vendors to try to get to the data
  - Used to determine indirect PE per HOUR
- Who completed the survey
  - 145 cardiologists – 90 tossed out
  - Used 50 surveys
    - 15.7% solo; 69.6% group practice; 9.2% multi-spec; and 5.5% academic
- What did this PPIS data show
  - **Cardiology expenses decreased 40%**
- What are we currently using
  - Supplemental survey data – collected by ACC

Cardiology Physician Practice Expenses
Percentage Trending



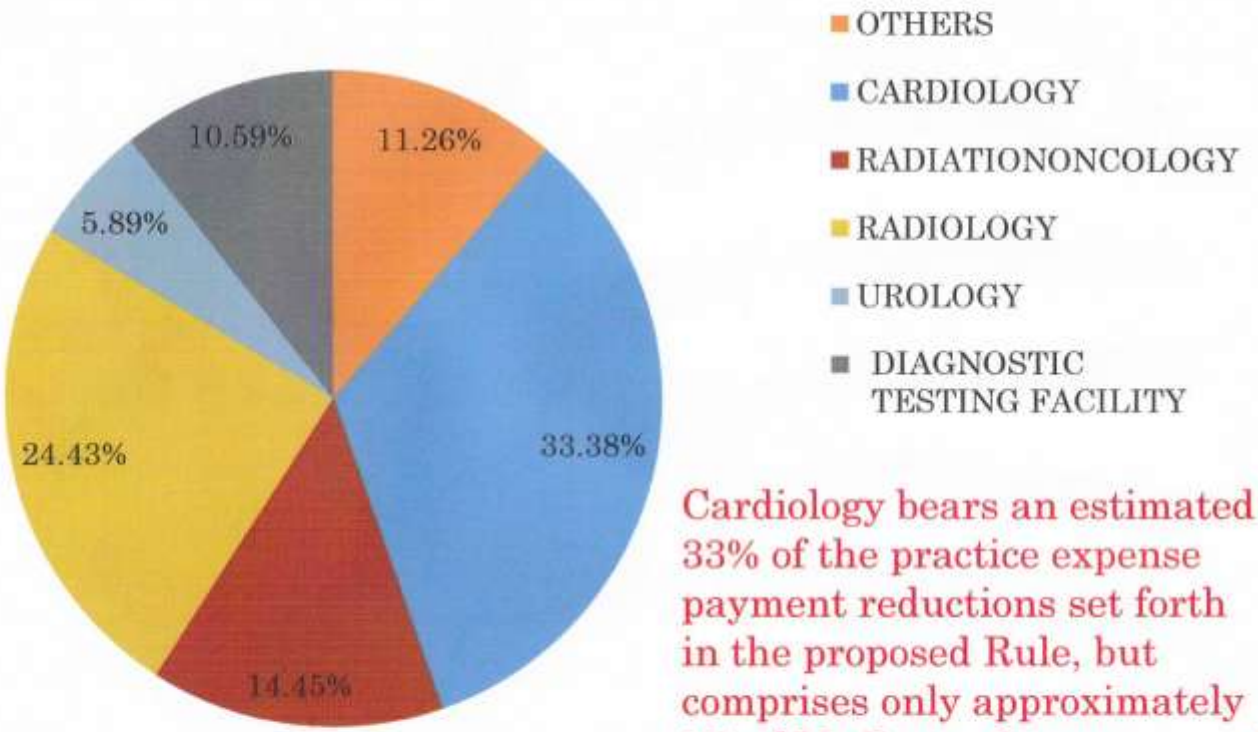
	2000	2001	2002	2003	2004	2005	2006	2007	2008
75%	$ 561,628	$ 605,628	$ 641,724	$ 652,618	$ 698,389	$ 723,790	$ 750,065	$ 742,492	$ 742,120
50%	$ 503,498	$ 535,010	$ 574,567	$ 587,776	$ 578,019	$ 606,705	$ 643,631	$ 624,880	$ 635,001
25%	$ 390,772	$ 436,685	$ 490,778	$ 465,564	$ 485,673	$ 508,627	$ 538,488	$ 532,271	$ 537,681

Final Rule PE Comments- Supporters

- Comment: In addition to MedPAC, numerous specialty groups and individual physicians and practitioners supported utilizing the PPIS data.
- The commenters included family practice, general practice, geriatrics, pediatrics, internal medicine, obstetrics and gynecology, general surgery, infectious disease, emergency medicine, psychiatry, anesthesiology, colorectal surgery, dermatology, endocrinology, gastroenterology, neurology, neurosurgery, ophthalmology, optometry, orthopedic surgery, osteopathic physicians, otolaryngology, pathology, physical medicine and rehabilitation, physical and occupational therapy, plastic surgery, podiatry, pulmonary disease, spine surgery, thoracic surgery, transplant surgery, and vascular surgery.

Impact By Specialty: Losers

Percentage of total reductions borne by select specialties, proposed 2010 fee schedule



Cardiology bears an estimated 33% of the practice expense payment reductions set forth in the proposed Rule, but comprises only approximately 9% of Medicare charges.

Source: American Society of Echocardiography 2009

For more information, please call CAA at 734.878.2108

CARDIOLOGY ADVOCACY ALLIANCE

2010 PFS MD to OPPS Reimbursement

2010:	2010 MD Global	2010 MD Technical	2010 Interp	2010 OPPS Hospital	2010 OPPS Hosp+Interp
Nuc - EF - WM (78465, 78478, 78480, 93015)	$ 474	$ 329	$ 142	$ 784	$ 926
Echo - Dop - CF (93306)	$ 145	$ 82	$ 63	$ 453	$ 516
Stress Echo (93351-MD, 93350-Hosp)	$ 203	$ 142	$ 70	$ 452	$ 532
Left Cath	$ 956	$ 512	$ 443	$ 2,672	$ 3,115

Physician Surveys

- Bottom Line: If you ever receive a physician work or practice expense survey: Please, Please, Please, – take the time to complete them as accurately as possible!

CPT Bundling: When Do We Get A Break?

- 2009 – Device follow-up codes, echo bundled, stress echo bundle, MCOT codes, Lexiscan
- 2010 – Nuclear code bundle, “real” CTA codes, cardiac MRI and removal of consult codes to Medicare
- 2011 – New cardiac cath bundled codes, PV lower leg extremity interventions bundled, new approach to rhythm monitoring
- 2012 – New bundled codes for generator changes, new bundled codes for selective renal procedures
- 2013- New PCI codes, New bundled EPS & ablations, bundled PV Head procedures

7 Categories of Services

1. Codes and families of codes for which there has been the fastest growth
2. Codes that have experienced substantial changes in practice expenses
3. Recently established for new technologies
4. Frequently billed in conjunction with furnishing a single service
5. Low relative values, and often billed multiple times for a single treatment
6. Not reviewed since implementation of RBRVS – Harvard-valued codes
7. Other as appropriate per the Secretary

Are We "Safe" Now?

- ACA - Use of Analytic contractors
- Potentially Misvalued Services – 5 additional categories
- Multispecialty Points of Comparison
- Expansion of Multiple Procedure Reduction
- Re-evaluation of global surgical packages

The Coding Team

Highly Clinical Codes

- The 2013 code changes are creating a challenge for many "coders"
- Hospitals and some practices are fortunate enough to have certified and trained coders – others are not
- Suggestion: Take the time to "walk through" your note with your coders and explain what measurements and components support the essential elements of a code

Documentation and Communication

- Making sure the required documentation is available in your note is critical
- Ensuring your coders understand and recognize those components is also important
- If you have separated yourself from the coding process… it's past time to reengage

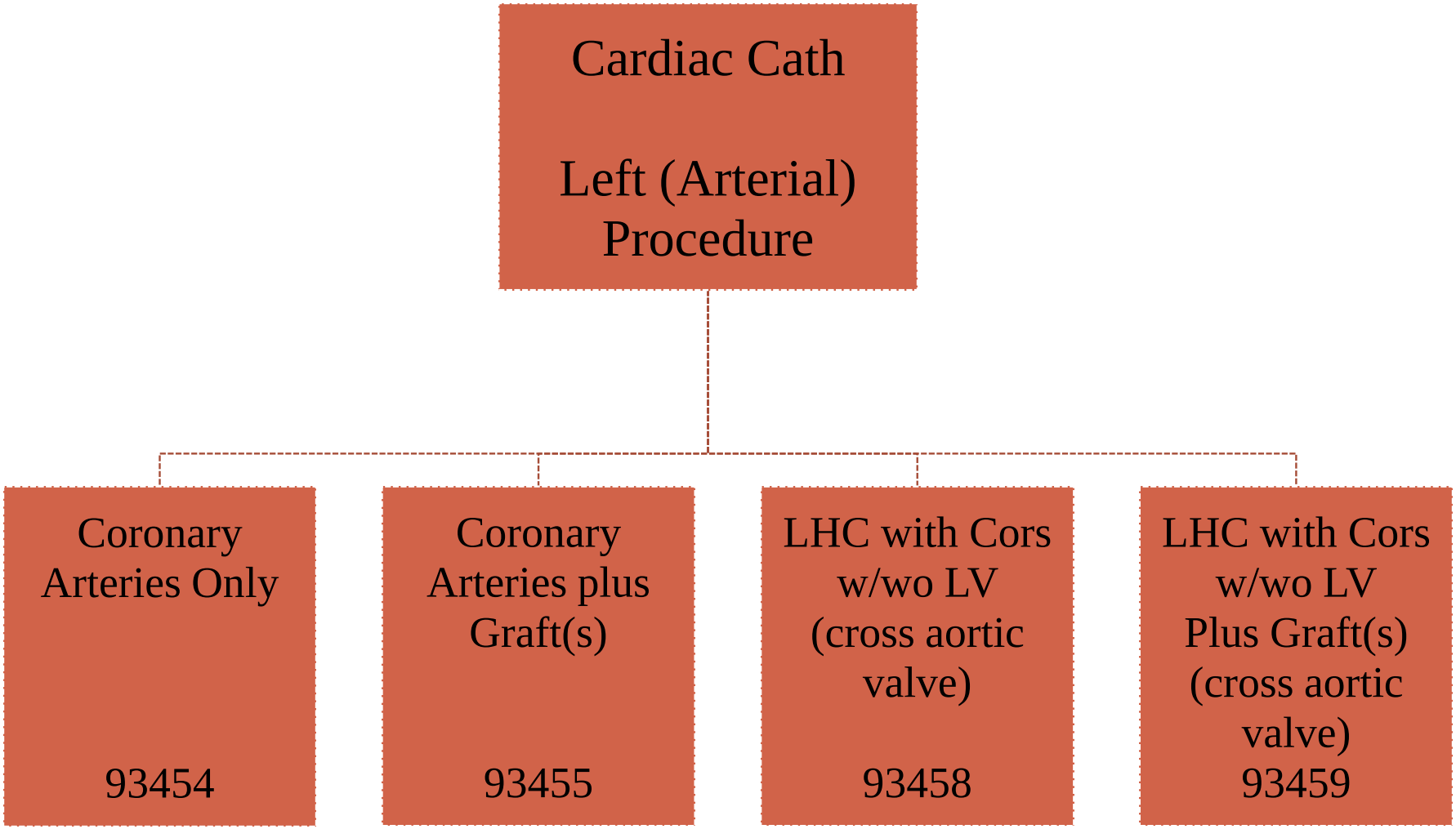
Cardiac Catheterization Codes

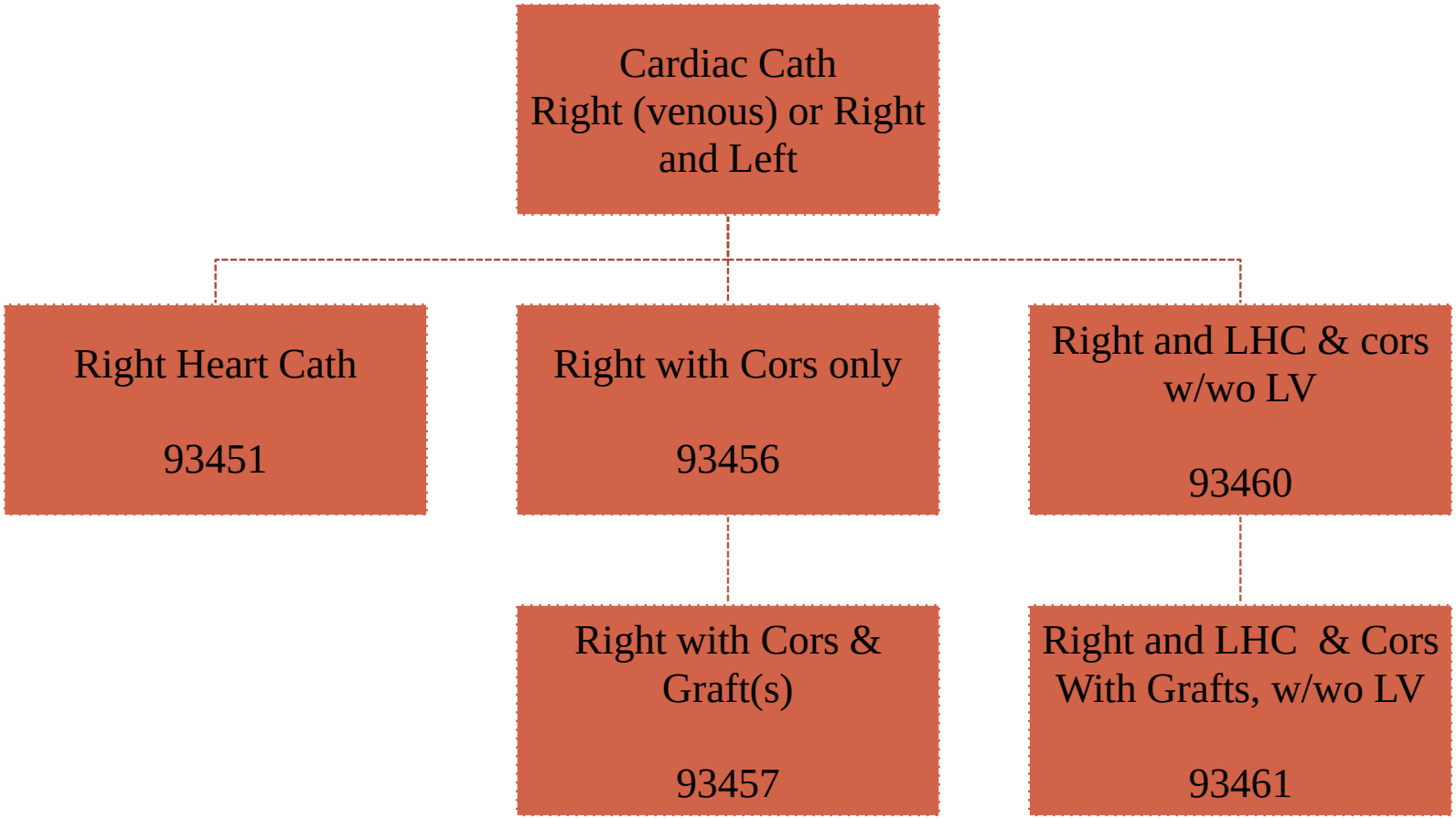
New Cath Codes

- The new codes have reduced the opportunity for many of the previous errors
- Some problem areas still exist, but not to the degree that they did prior

Typical Problem Areas

- Coronary angiography versus LHC
- Billing unbillable nonselect cath placement codes (36140, 36200)
- G0275 – nonselect renal
- G0278 – nonselect extremities
- Cath with an intervention
- Automated reports and add on services such as IVUS, flow wires, and selective PV


Cardiac Cath
Left (Arterial) Procedure
Coronary Arteries Only
93454
Coronary Arteries plus Graft(s)
93455
LHC with Cors w/wo LV (cross aortic valve)
93458
LHC with Cors w/wo LV Plus Graft(s) (cross aortic valve)
93459


Cardiac Cath
Right (venous) or Right and Left
Right Heart Cath
93451
Right with Cors only
93456
Right and LHC & cors w/wo LV
93460
Right with Cors & Graft(s)
93457
Right and LHC & Cors With Grafts, w/wo LV
93461

Cardiac Catheterization & PCI

- One of the most frequent errors is ensuring the cardiac catheterization codes are NOT billed in conjunction with a PCI if it is not the diagnostic catheterization
- Criteria is now provided in the introductory language of CPT
- It's imperative that you have the diagnosis, and better yet a brief sentence or two of history in the PCI note itself

Diagnostic Catheterization Criteria

- 1) No prior catheter-based coronary angio study is available, and a full diagnostic study is performed, and a decision to intervene is based on the diagnostic angiography
- 2) A prior study is available, but as documented in the medical record:
  - The pt's condition with respect to the indication has since changed
  - Inadequate visualization of anatomy and/or pathology
  - "There is a clinical change during the procedure that requires new evaluation outside the target area of intervention."

Documentation Improvement

- Many automated or "click on" reports will require a number of updates in order to code appropriately
- Indications:
  - Improved documentation of AMI procedures
  - Name the AMI "Culprit" lesion – especially if more than one is treated
  - Clearly note CTO lesion and document appropriate criteria i.e. "absence of antegrade flow accompanied by suggestive angiographic and clinical criteria (eg, bridging collaterals present, calcification at the occlusion site, no current presentation with ST elevation or Q wave AMI). Greater than 3 month duration.
  - Clinical indications/changes for any "repeat" diagnostic cardiac cath

PCI – Documentation Suggestions

- Clearly document bifurcation interventions and be very specific as pertains to parent versus branch interventions
- Make sure you and your coders are clear on bypass code – in or through a bypass graft
- Clarify lesion locations and procedures on each – avoid "the lesion" – name it.
- Make sure you are billing the thrombectomy code appropriately

CTO Procedures

- Coders are expressing confusion on this one – ensure they understand the difference between a CTO and a 100% obstruction
- Anticipate that commercial payors in particular will request documentation in support of CTO procedures – many consider this noncovered without extenuating circumstances

New EP Device Codes

- Here too the new codes should help reduce one of the problem areas such as fluoroscopy being billed but not always documented
- There has been a considerable amount of confusion surrounding the use of the generator change codes and in particular related to the conversion of a PM to a Biventricular device
- AMA published a clarification document on Feb 27, 2012 to clarify the 33225 (LV lead with new generator) CAN be used in conjunction with the generator change only codes

PACEMAKER INSERTION	ICD INSERTION
New System &/or Generator + Lead	**New System &/or Generator + Lead**
____ 33206 - Single – Atrial	____ 33249 – Single or Dual ICD
____ 33207 - Single - Ventricular	____ 93641 DFT Eval Lead & Generator
____ 33208 - Dual – Atrial & Ventricular	____ 33225 LV Lead with New Generator
____ 33225 LV Lead with New Generator	
(The above codes apply to the entire system.)	
GENERATOR CHANGE ONLY (no Rt lead procedure)	**GENERATOR CHANGE ONLY** (no Rt lead procedure)
Includes Generator Removal & Replacement	**Includes Generator Removal & Replacement**
____ 33227 – Single, Atrial or Ventricular	____ 33262 – Single, Atrial or Ventricular
____ 33228 – Dual, Atrial & Ventricular	____ 33263 – Dual, Atrial & Ventricular
____ 33229 – Multi, includes LV Lead	____ 33264 – Multi, includes LV Lead
____ 33225 LV Lead with New Generator	____ 33225 LV Lead with New Generator
	____ 93641 DFT Testing
GENERATOR CHANGE + R Lead Procedure	**GENERATOR CHANGE + R Lead Procedure**
Generator removal is billable, Lead removal is billable	**Generator removal is billable, Lead removal is billable**
Select "System" Code to match what was done.	**Select "System" Code to match what was done.**
____ 33206 - Single – Atrial	____ 33249 – Single or Dual ICD
____ 33207 - Single - Ventricular	____ 93641 DFT Eval Lead & Generator
____ 33208 - Dual – Atrial & Ventricular	____ 33225 LV Lead with New Generator
ADD ON SERVICES:	**ADD ON SERVICES:**
____ 33233 Generator Removal	____ 33241 Generator Removal
____ 33234 Remove Atrial or Ventricular Lead	____ 33244 Remove Atrial or Ventricular Lead (ICD)
____ 33235 Remove Dual Lead	____ 33234 Remove A or V lead (PM)
____ 33225 LV Lead with New Generator	
INITIAL GENERATOR Attached to EXISTING LEADS	**INITIAL GENERATOR Attached to EXISTING LEADS**
____ 33212 – Attached to Single (A or V) Lead	____ 33240 – Attached to Single (A or V) Lead
____ 33213 – Attached to Dual (A & V) Lead	____ 33230 – Attached to Dual (A & V) Lead
____ 33221 – Attached to LV Lead	____ 33231 – Attached to LV Lead
	____ 93641 DFT Eval Lead & Generator

Separately Billable VS Inclusive

"Add on" Ablation Codes	Separately Billable
• "And then another arrhythmia emerged" • Protect yourself from both lost revenue and potentially inappropriate use by making this crystal clear in your note	• What is separately billable and what is inclusive is unique to the ablation code being submitted • Make sure you have good tools and a solid understanding of the codes • Introductory language in CPT is a valuable educational tool all EP providers should review

EP COMP STUDIES

____ **93653-26 - Complete EP Study & SVT Ablation**
- ____ 93621-26 LA Pace & Record
- ____ 93623-26 Medication Testing
- ____ 93609-26 Mapping
- ____ 93613 3-D Mapping

- ____ 93655-26 Ablate Discrete Mechanism

____ **93656-26 – Complete EP Study & AFib Ablation (PVI)**
(Includes Transseptal & LA Pace / Record)
- ____ 93613 3-D Mapping
- ____ 93623-26 Medication Testing
- ____ 93662-26 ICE
- ____ 93609-26 Mapping

- ____ 93657-26 Ablate Add'l. AFib
- ____ 93655-26 Ablate Add't. NOT AFib

____ **93654 – Complete EP Study & VT Ablation**
(Includes Mapping & LV Pace / Record)
- ____ 93655-26 Ablate Discrete Mechanism

____ **93650-26 AV Node Ablation**

____ **93620 – Complete EP Study w/Induction Attempt**
____ **93619 – Complete EP Study w/OUT Induction Attempt**
- ____ 93621-26 LA Pace & Record
- ____ 93623-26 Medication Testing
- ____ 93609-26 Mapping
- ____ 93613 3-D Mapping

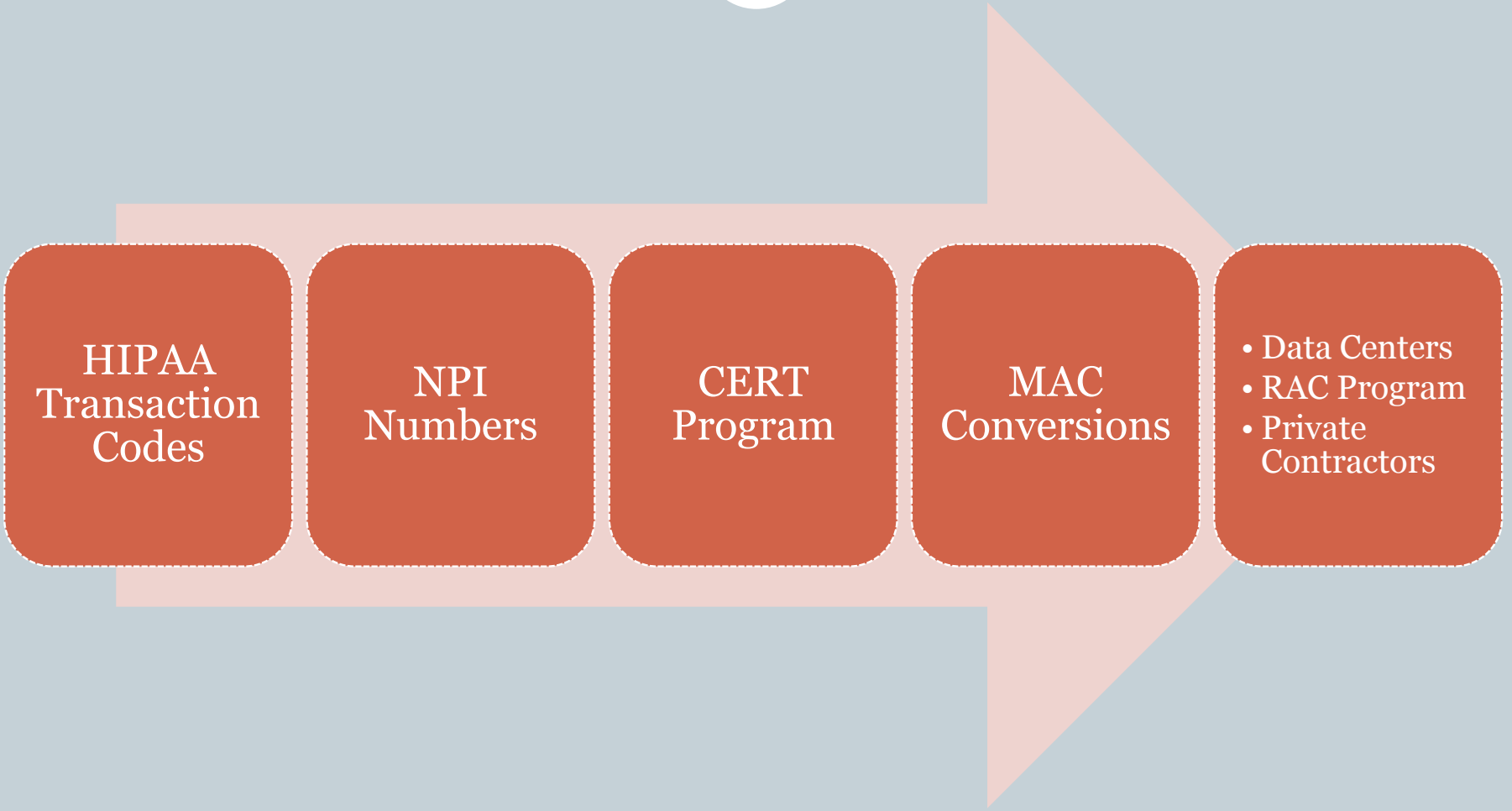
The Age Of Data Analysis

Question: Who is looking at your claims data?

Answer: Pretty much every payor

- Diagnosis data reviewed for severity, cost and quality programs, etc.
- CPT data – hunting for opportunity to identify improper code combinations, comparisons to peers, etc.

Setting The Stage?



RAC Reviews

Review Types

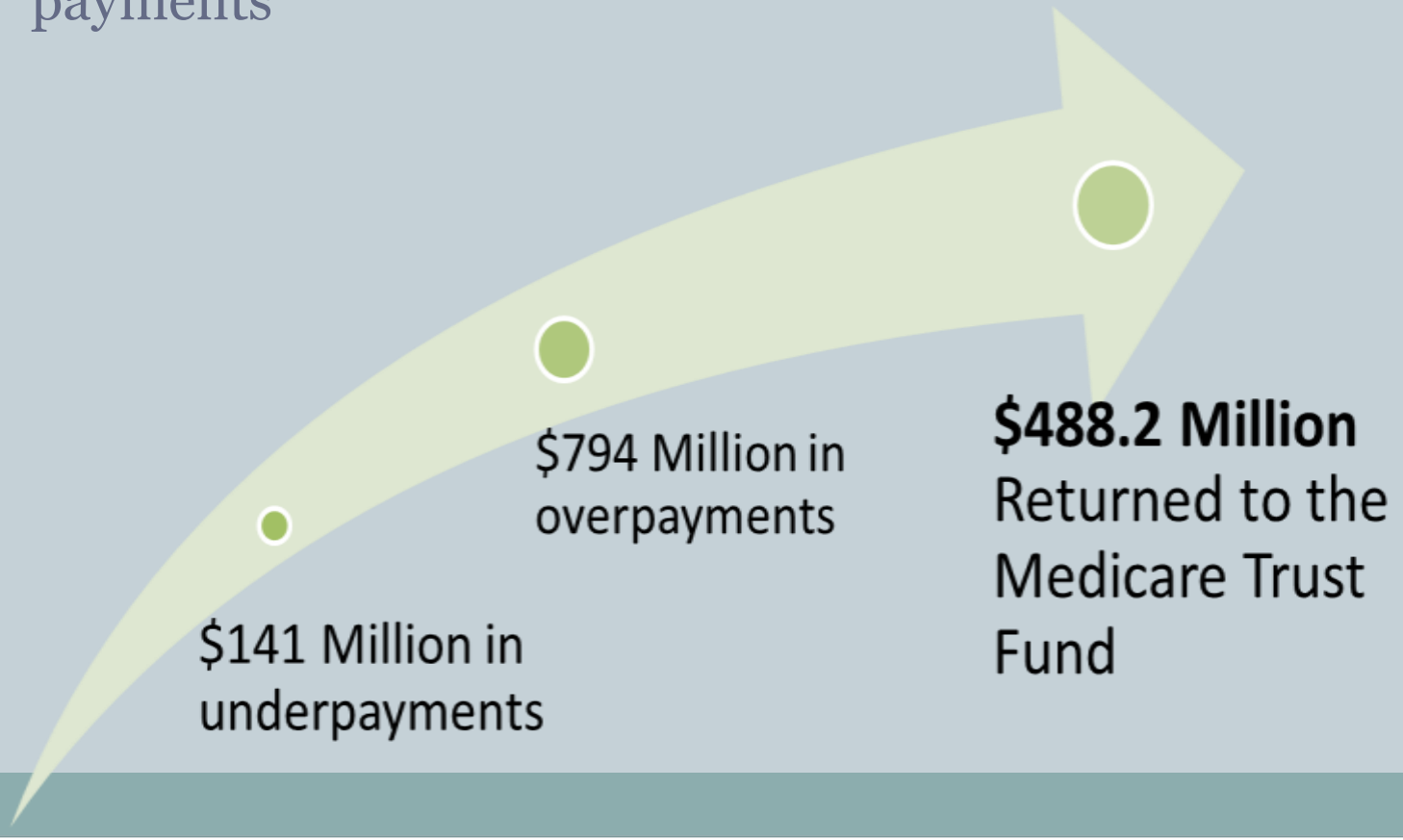
1) Automated Review

2) Complex Review

- Use OIG and GAO reports to help identify vulnerable areas
- Use claims data and "proprietary techniques"
- Required to "post" CMS approved list of projects/focus
- Must follow guidelines established by local MAC and or CMS Nat'l when available
- Free to apply their own criteria if other guidelines are not available

FY11 Report To Congress

- The full report is available at CMS.gov/RAC
  - FY 2011 – identified and corrected $939 million in improper payments



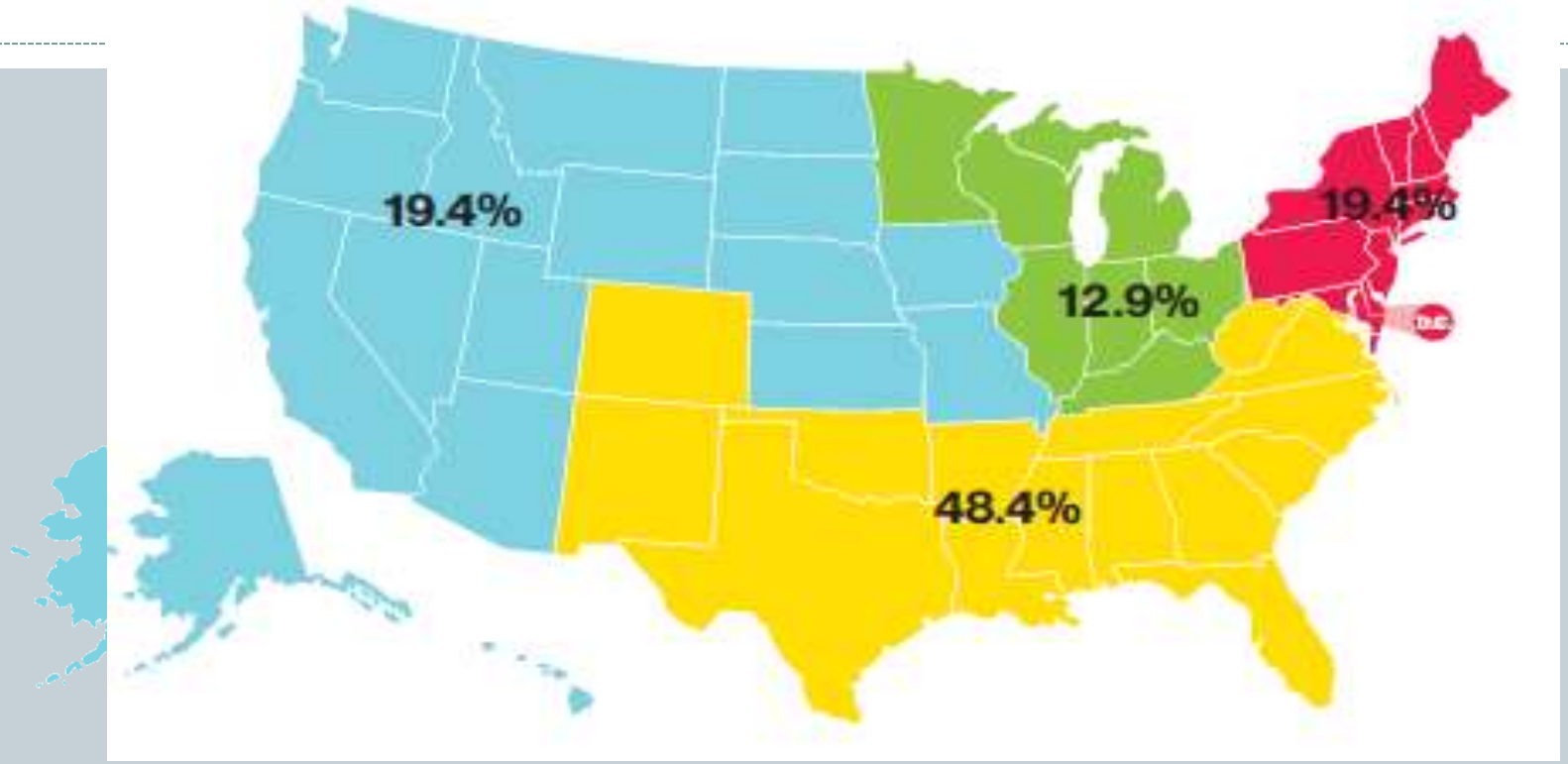
A Change In Approach?

- Most of the current CMS efforts involve a “post payment” review
- The “new” approach is a shift to “pre-payment” reviews
  - 7 states with high fraud and error prone providers: FL, CA, TX, MI, NY, LA, Ill
  - 4 states with high volume of short stays: PA, OH, NC, MO

  Keep your eyes on this area – we should anticipate expansion

National RAC Landscape

PERCENTAGE (%) REPRESENTS RACS REPORTED IN SURVEY



Fall 2011 BOCN MedAxiom Regulatory Audit Intelligence Report

Demand Letter

Date

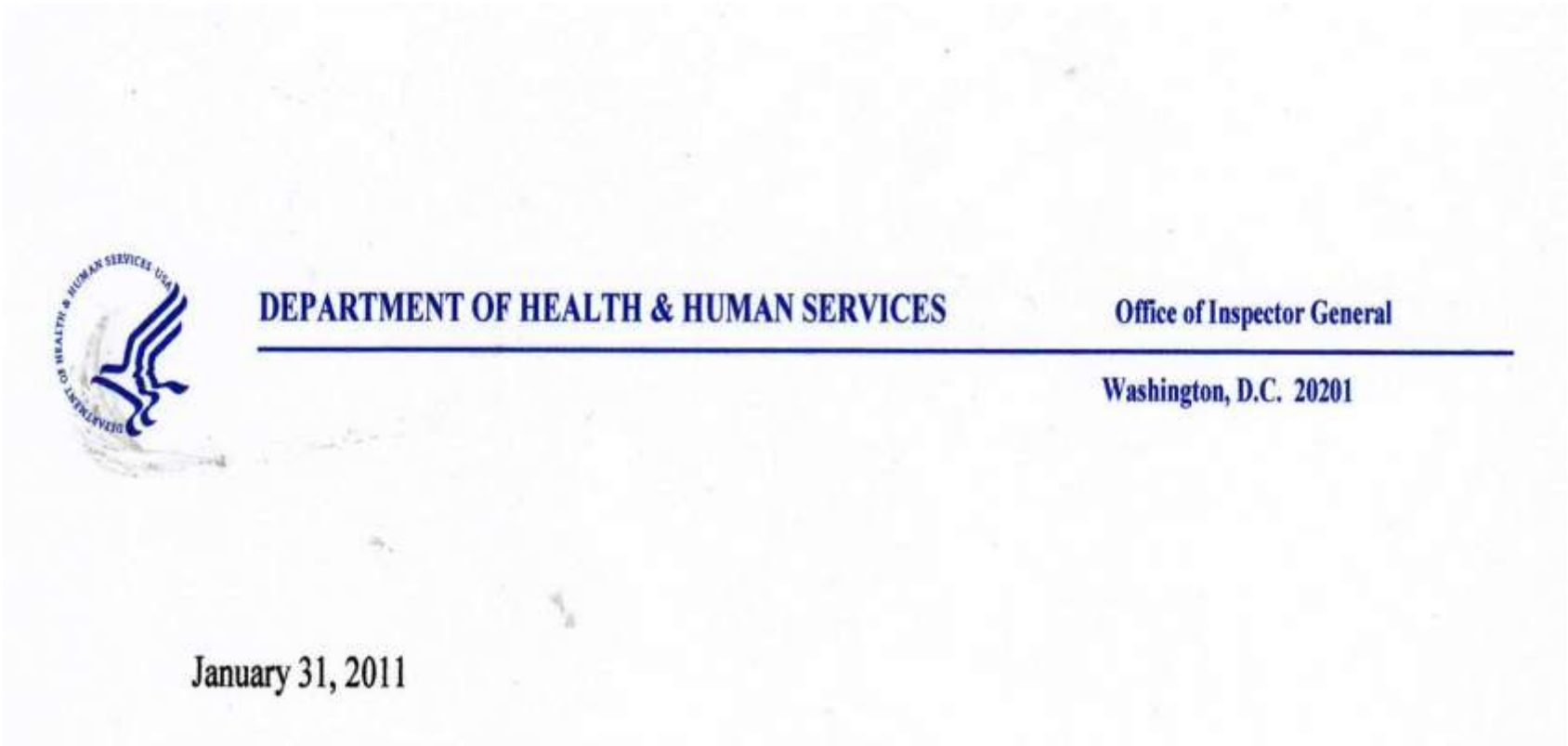
RAC Point of Contact
Provider Name
Address 1
Address 2
City, State Zip

Re: Provider Name #123456789
Letter ID: XXXXXX
Issue: (Issue Name)

Dear Medicare Provider,

The Centers for Medicare & Medicaid Services (CMS) has retained CGI Federal to carry out the Recovery Audit Contracting (RAC) program in the State of _____. The RAC program is mandated by Congress aimed at identifying Medicare improper payments.

Where Eagles Fly…

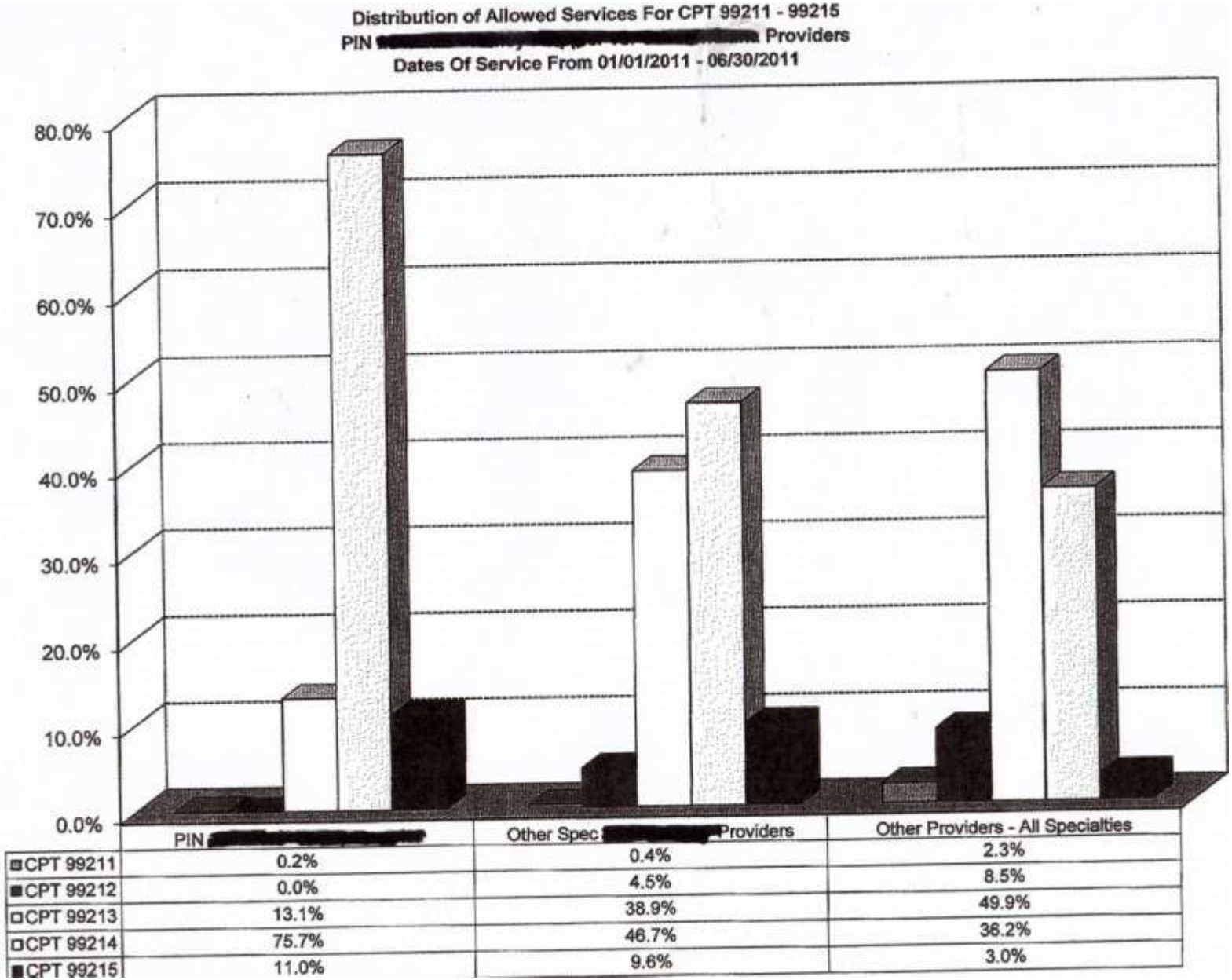


DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

January 31, 2011



	PIN [redacted]	Other Spec [redacted] Providers	Other Providers - All Specialties
CPT 99211	0.2%	0.4%	2.3%
CPT 99212	0.0%	4.5%	8.5%
CPT 99213	13.1%	38.9%	49.9%
CPT 99214	75.7%	46.7%	36.2%
CPT 99215	11.0%	9.6%	3.0%

Wisconsin Physicians Service (WPS) is the Medicare Administrative Contractor (MAC) for Jurisdiction 8 (Indiana and Michigan). We are responsible to educate providers so that services provided to Medicare beneficiaries are properly documented and coded for accurate claim adjudication. Periodically, we analyze provider coding patterns to identify deviations from a peer group. The purpose of this letter is to inform you, based on Medicare claims data for your state, that your coding pattern is significantly different from that of your peers. We hope the information in this letter and in the attachments will help you to evaluate your current coding and billing practices.

The enclosed Comparative Billing Report (CBR) contains your data compared to other Indiana providers within your specialty who bill CPT codes 99231-99233. An indicator of a problematic billing pattern is little or no variation in the level of services within an Evaluation and Management (E/M) category. Because the nature of the patient's presenting problem(s) and the amount of work necessary to address them will vary, the billing pattern of E/M services should vary in level. Your pattern indicates at least 90% of the time you billed only CPT code 99232 within the range of CPT codes 99231-99233.

You may be aware that the Centers for Medicare & Medicaid Services (CMS) conducts the Comprehensive Error Rate Testing (CERT) program to identify and correct Medicare claim payment errors. Currently, CERT's claim sampling focuses on services with a historically high rate of errors on a national level. As a result of CERT error findings, E/M CPT codes have been selected for review in the CERT national sample for Medicare claims submitted in calendar year 2012.

Analysis of CERT errors for claims submitted 01/01/11 through 12/31/11 indicates E/M CPT codes 99231-99233 were in error approximately 34% of the time. Incorrect coding accounted for the largest portion of all errors assessed. The desired outcome of both the national CERT initiative and our WPS education efforts is to increase claim payment accuracy.

WPS Medicare encourages you to perform a self audit of your Medicare billings. For information on conducting a self-audit, please refer to the Office of Inspector General (OIG) Website document at: https://oig.hhs.gov/authorities/docs/physician.pdf. If you determine error(s) have occurred, please refer to the WPS Medicare websites listed below for corrective action procedures. Please note, we will continue to monitor your Medicare billings and expect to see appropriate changes.

MAC Sample On Coding Patterns

- The nature of the patient's presenting problem will vary, so will the amount of work necessary to address the problem. Providers must choose procedure codes based on the service they provided to the patient on that day. Medicare considers the claim in error when the service is either over or under-coded.
- "I'm a specialist", "People send their sicker and needier patients to me". – Choose codes based only on the services provided to the patient on that day. Documentation must support both the service billed and the medical necessity of that service

Sample Comparative Report – Testing

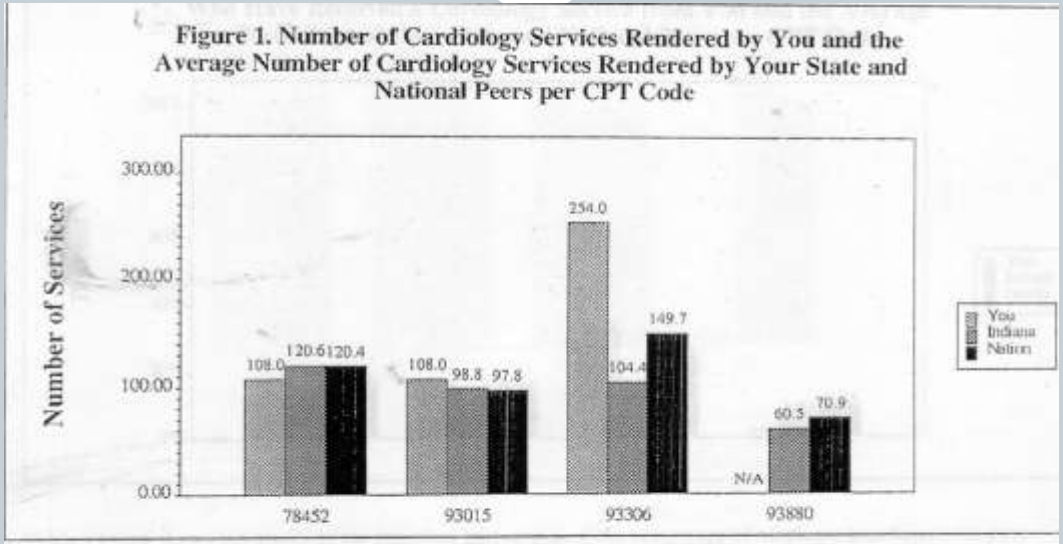


Table 1 below shows the results of the statistical comparison of the number of cardiology services rendered by you to the average number of cardiology services rendered by your state and national peers per CPT code. A statistical test was used to determine if there was a significant difference between the number of cardiology services rendered by you and the average of your state and the nation.

Table 1. Statistical Comparison of the Number of Cardiology Services Rendered by You to the Average Number of Cardiology Services Rendered by Your State and National Peers per CPT Code

	You	Indiana			Nation		
CPT Code	Number	Number	Difference	Significance*	Number	Difference	Significance*
78452	108.0	120.6	-12.6	within the norm	120.4	-12.4	lower
93015	108.0	98.8	9.2	within the norm	97.8	10.2	higher
93306	254.0	104.4	149.6	higher	149.7	104.3	higher
93880	N/A	60.5	N/A	N/A	70.9	N/A	N/A

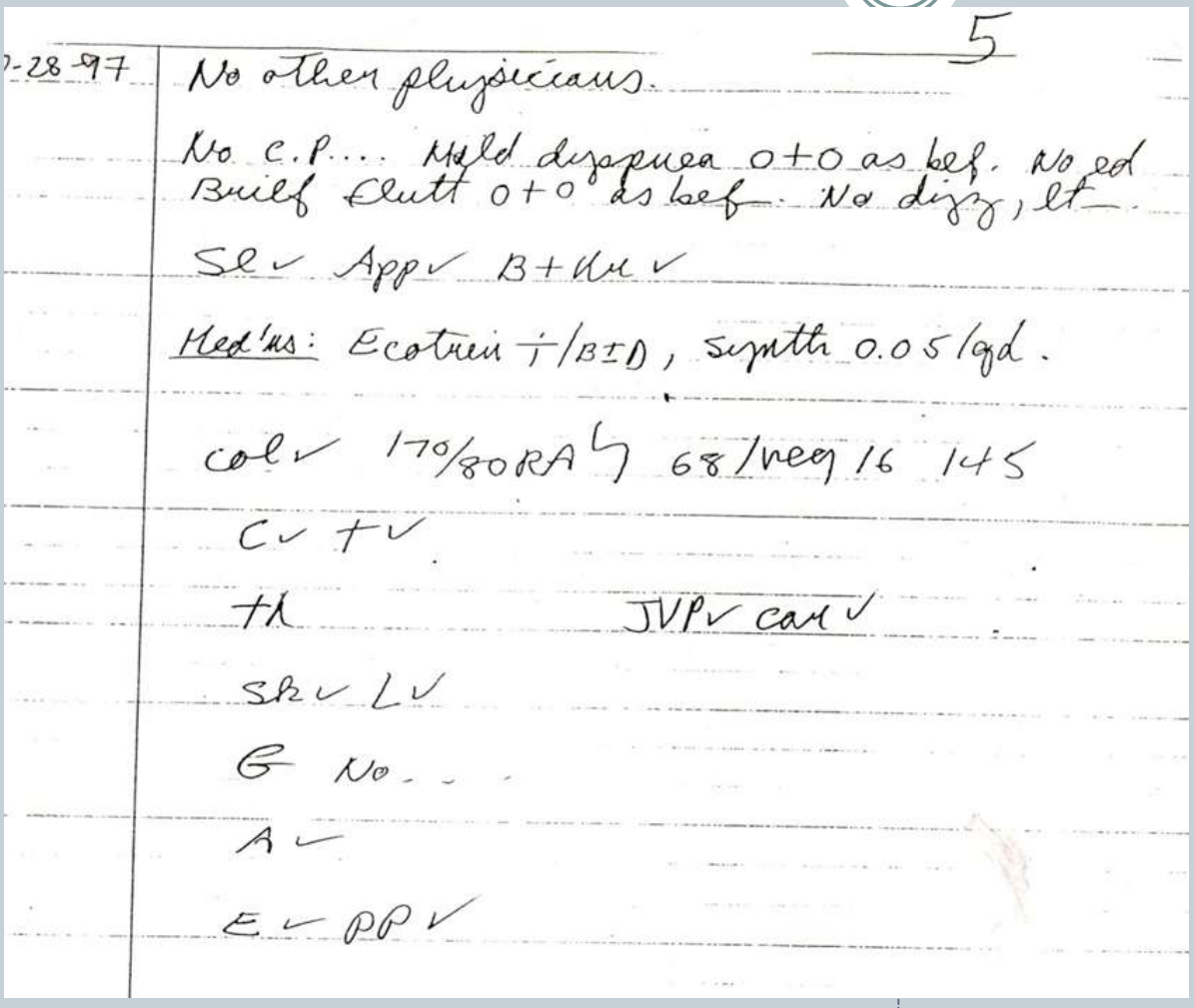
CBR From CMS

- CBR Services Overview
- The Centers for Medicare & Medicaid Services (CMS) awarded the Comparative Billing Report (CBR) contract to SafeGuard Services LLC (SGS). A Comparative Billing Report or CBR is a documented analysis that shows a provider's billing pattern for various procedures or services and compares that billing to their peers.
- CMS has authorized SGS to begin producing nationwide CBRs beginning in 2010. SGS, as the CBR Producer, has begun to develop an inventory of potential topics for study. CBRs will be produced using national data from Medicare A, B and DME. Once each study has been completed, the CBR will be mailed or faxed to the providers that were selected under the topic criteria. A maximum of 5,000 providers will be selected per CBR topic. The CBR, approximately 4 pages in length will also be distributed to each provider in a PDF format. If, after reviewing the document the provider has any questions, they would then be able to call into the SGS CBR support team, whose contact information will be provided on each CBR.
- The CBR is not intended to be punitive or sent as an indication of fraud. Rather it is intended to be a proactive statement that will help the provider identify potential errors in their billing practice. A CBR contains peer comparisons which can be used to provide helpful insights into their coding and billing practices. The information provided is designed to help the provider prevent improper billing and payment.

Commercial Payors

- Don’t forget the commercial payors are also conducting data review along with auditing and monitoring.
- The AMA’s E/M guidelines apply to all payors, and most payors do have additional educational resources they make available to providers.
- You will also want to be aware of any “cost & quality” data they are making available to you

Just A Comment….



5

-28-97 No other physicians.

No C.P.... Mild dyspnea o+o as bef. No ed
Brief Clutt o+o as bef. No dizzy, lt.

Sl ✓ App ✓ B+Ht ✓

Med's: Ecotrin +/BID, synthr 0.05/qd.

col ✓ 170/80 RA 68/reg 16 145

C ✓ + ✓

+ R JVP ✓ car ✓

Sk ✓ L ✓

G No...

A —

E — PP ✓

Never underestimate the power of your pen

In Case You Are Wondering….

This is NOT the correct response

"Unofficial" Top 10 E/M Errors From This Auditor's Perspective

1) Less than 10 systems in a ROS when a comprehensive history is required
2) Missing a family or social history when a comprehensive history is required
3) Billing at a high level of medical decision making when the code is better as a moderate
4) Not having the required exam elements on a hospital level 3 follow-up visit
5) Problems with "incident to" (office setting) documentation
6) Problems with "split/shared" visit documentation in the hospital setting
7) Visit does not clearly identify a "significant and separate" condition on the day of a procedure or within a global period
8) Not clearly documenting the consultation request when the consult code is billed
9) Conflicting information in the HPI versus the ROS with electronic medical records
10) Not clearly documenting the patient's "new pt" status

Arm Yourself : Read The Book !
AMA CPT, ACC Coding Guide, etc.

- ACC web (Cardiosource) – Available on demand replay of training on E/M Errors as well as working with Non-Physician providers
- The newer procedure codes themselves, as well as the introductory language are very well written
- Take the time to arm and educate yourself by reading the pages that apply to your services


You
Tube

One More Comment…..

ICD-10 Implementation

CMS QRUR Reports

- Quick Reference Guide for Accessing the 2012 Quality and Resource Use Reports (QRURs)
- Available for group practices with 25 or more eligible professionals (EPs).
- More information about the QRURs is available at http://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeedbackProgram/ReportTemplate.html.
- The QRUR will preview each group's performance on quality and cost measures that could be used to calculate the group's Value-Based Payment Modifier in 2015.
- More information
- about the Value-Based Payment Modifier and quality-tiering is available at http://www.cms.gov/Medicare/Medicare-Feefor-Service-payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

ICD-9 Codes – Diagnosis Codes

- They haven't always gotten the respect they deserve

- They communicate why we did what we did for our patients
- They are linked to the CPT procedure code to establish medical necessity
- They are being used by payors to help assess our "quality" and cost effectiveness
- We need to be focusing on accurately reporting severity and comorbidities

		TOTAL		PROFESSIONAL		MEDICAL/ SURGICAL		ANCILLARY		HOSPITAL INPATIENT		INPATIENT PROFESSIONAL		PHARMACY	
MEDICAL CONDITION	EPISODES	AVG COST	PEER AVG COST	AVG COST	PEER AVG COST	AVG COST	PEER AVG COST	AVG COST	PEER AVG COST	AVG COST	PEER AVG COST	AVG COST	PEER AVG COST	AVG COST	PEER AVG COST
Ischemic Heart Disease - SOI 1	33	7,276	2,087	218	177	833	71	3,228	1,004	2,034	177	215	37	748	620
Acute Myocardial Infrct, Active - SOI 1	1	38,660	23,456	78	264	0	72	35,876	2,546	132	17,417	1,805	2,173	770	985
Hypertension - SOI 1	3	448	654	141	134	0	2	190	187	0	23	0	2	118	306
Ischemic Heart Disease - SOI 2	4	14,259	6,650	400	227	253	171	9,612	2,151	1,776	2,318	214	292	2,004	1,492
Diabetes with Circulatory - SOI 1	13	9,707	4,965	374	370	5,054	317	3,182	2,166	604	726	31	105	463	1,279
Diabetes with Circulatory - SOI 2	1	23,948	17,351	403	540	14,701	658	6,018	4,693	0	8,762	0	1,108	2,827	1,590

Aetna PPO with Aexcel	Aexcel-Designated Specialists	Non-Designated In-Network Specialists	Other Specialists (outside the 12 Aexcel specialty areas)	Out-of-Network Specialists
Coinsurance	90%	80%	90%	70%
Deductible (Employee Only)	$250	$250	$250	$250
Coinsurance Limit* (Employee Only)	$1,000	$1,000	$1,000	$2,000
Specialists Copay/Coinsurance	$15	$30	$30	70%

Aetna EPO with Aexcel	Aexcel-Designated Specialists	Non-Designated In-Network Specialists	Other Specialists (outside the 12 Aexcel specialty areas)	Out-of-Network Specialists
Coinsurance	100%	90%	100%	Not covered
Deductible (Employee Only)	$0	$0	$0	Not covered
Coinsurance Limit* (Employee Only)	$0	$500	$0	Not covered
Specialists Copay/Coinsurance	$10	$30	$30	Not covered

ICD-10-CM

- On October 1, 2014, the United States will move from the ICD-9 system to ICD-10
- It is the "most significant overhaul of the medical coding system since the advent of computers." –The WEDI Workgroup
  - Approximately 9 times more ICD-10 codes
  - More complex than HIPAA compliance
  - Will touch most operational and IT processes and dramatically influence data and financial reporting strategies

Is There A Silver Bullet?

Are you already behind?

- The challenges and opportunities associated with ICD-10 implementation will in many ways be unique to your organization.
- Are you implementing for a single specialty or multiple specialties?
- Are you in a paper environment or an electronic record(s), are you planning any conversions?
- How stable is your organization between now and October 2014? Are you anticipating mergers, growth, etc.?

How Do We Really Compare?

Nation	Size of Code Set	Clinical Setting For Use	Funding to Providers	Pilot Testing?
United States ICD-10-CM	**68,000**	**Inpatient and outpatient**	**None**	**No**
Australia ICD-10 AU	22,000	Inpatient only	Government	Yes
Canada ICD-10 CA	17,000	Inpatient only	Government	Yes
Germany ICD-10-GM	13,300	Inpatient and outpatient	Government	Yes

Not Just For Coders

- Coders can't code what's not documented so there will be a concurrent physician/clinician impact
- Physicians "code" when they mark or "click" a diagnosis on an encounter form or electronic record
- **It's not just about the "code" – it's about the diagnosis or condition**
- How much of what we do and bill for does not involve the reason we are doing it?

Consider Your Overall Impact

1

- Previsit – scheduling, registration, precertification
- Referring physicians provide us with info (interp, referrals etc.)

2

- Delivering care: Physicians, clinical staff, technicians
- Communicating Info – orders, order sets, registries, etc.
- Care delivered: Office, Hospital, interp only services

3

- Reimbursement: Coding, billing, denials, matching dx to procedure
- Reports: Quality initiatives, trending, tracking, reporting

What Do Those "Buckets" Have In Common?

1. People – Think about impact per job duty and or function - Role based approach
2. Process/Procedure – Think about the processes followed by the people as they perform their duties
3. Technology/tools – Consider what systems, and or tools are involved – anywhere you might find a diagnosis

You May Have Seen The Comparisons…

Diagnosis Codes	Procedure Codes
ICD-10-CM	ICD-10-PC
Hosp and Physicians	**Hosp only**
ICD-9 14,315	**ICD-9 3,838**
ICD-10 69,099	**ICD-10 71,957**

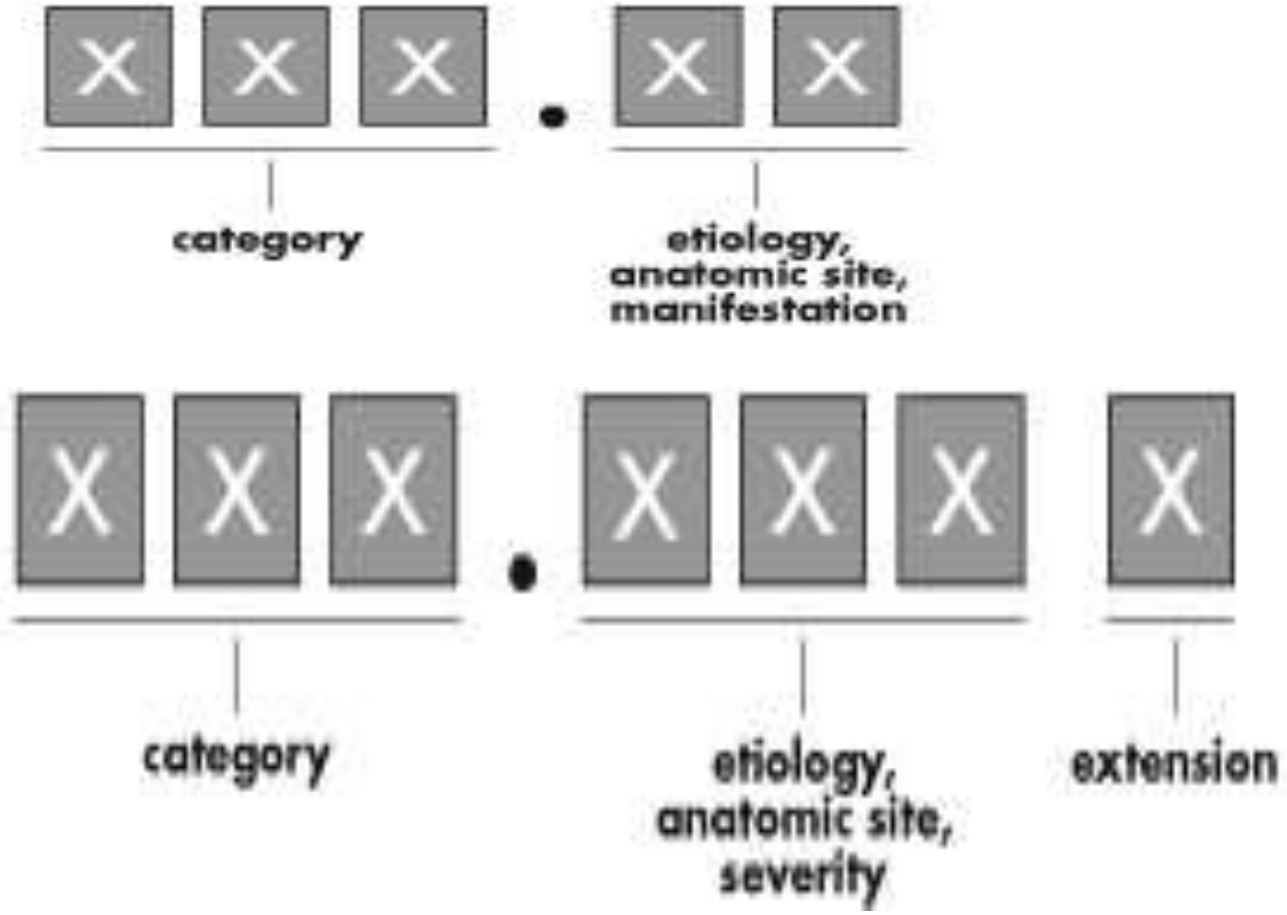
In Little Teeny, Tiny Print

3.7 POUNDS of codes

CAD: 6 inches to 6 feet
DM: 1.8 feet to 6.8 feet
CVD: 3.7 feet to 19 feet

Need A Visual?

Number of Characters – 3-7



Understanding The Impact Of The Changes

1. Volume of codes
2. Number of characters
3. Structure of characters
4. “Placeholder” concept
5. Laterality is included when appropriate
6. More extensive use of combination codes, and manifestations
7. Category restructuring, code organization, and disease reclassifications for some conditions
8. Definition and terminology changes
9. Application of general updates in knowledge and disease states reflecting 30 years of changes
10. More “notes” – Excludes 1, Excludes 2,

Structure of Characters

- The first character will be an alpha character – all are used except for "U"
- The second character will be numeric
- The third through the seventh – can be alpha and or numeric
- Implementation Issue – we now have use of both the alpha "O" and numeric "0" zero, Not to mention alpha "I" and numeric "1"

Do you have font options?

- Calibri – O, 0, I, 1
- Times new roman – O, 0, I, 1
- Consolas – O, 0, I, 1

Sample Codes Of Differing Character Lengths

- Chapter 9 – Diseases of the circulatory system – Codes I00- I99
- **I10** – Essential Hypertension
- **I25.2** – Old Myocardial Infarction
- **I51.81** – Takotsubo syndrome
- **I63.231** – Cerebral infarct due to unspecified occlusion or stenosis of right carotid artery

No 7 digit requirements for Chapter 9 – but we'll still use some 7 digit codes:

- **T82.111A** – Breakdown (mechanical) of cardiac pulse generator (battery), initial encounter

Placeholder Concept

- ICD-10 uses an “x” as a placeholder in some conditions
- There is also a chapter that starts with “X”
- The “x” placeholder is inserted in the 5th or 6th position for example so that you can still provide the information represented by the 6th and/or 7th character

Example – Placeholder "X"

- If the patient has an infection due to cardiac valve prosthesis - we'll look to T82.6
- This code requires that we also provide the "episode" character (in addition to an add'l code to identify the infection itself)
- The Episode character goes in the 7th character position

A – initial encounter, D- subsequent, or S- sequela

If this is our initial encounter then we would report T82.6XXA - Infection and inflammatory reaction due to cardiac valve prosthesis – initial episode

Laterality - Left, Right, Bilateral

I70.21 – Atherosclerosis of native arteries of extremities with intermittent claudication

Must go on to say

- I70.211…right leg
- I70.212… left leg
- I70.213…bilateral legs
- I70.218…other extremity
- I70.219 …unspecified extremity

M79.60 Pain in limb unspecified

Must go on to say for example:
M79.601 Pain in right arm
M79.602 Pain in left arm
There are also options for:
M79.621 Pain in right upper arm
M79.631 Pain in right forearm
M79.641 Pain in right hand
M79.644 Pain in right finger

Combination Codes

- In ICD-10 we see combination codes for some conditions and their most common associated symptoms and manifestations
- Example: I25.110 Atherosclerotic heart disease of native coronary artery with unstable angina pectoris
- “CAD” will not be enough info to do anything with
- How will we abbreviate this?
- CAD, native, with UA?

Top Cardiology Conditions

1) Chest Pain
2) A Fib
3) CAD Native
4) Unstable Angina
5) Shortness of breath
6) CHF
7) S/P ICD
8) S/P PM
9) Abn'l EKG
10) Angina Pectoris
11) Hyperlipidemia
12) CAD unspec
13) HTN
14) Acute MI
15) Syncope
16) Cardiomyopathy
17) Aortic valve disorder
18) Palpitations
19) Anticoagulation disorder
20) Mitral valve disorder
21) PSVT
22) S/P PTCA

ICD-10 CM For Cardiology

- Chapter 9 - Our primary chapter - Code ranges of I00-I99
- Chapter 18 – Signs, symptoms, abnormal findings – R codes
- Chapter 21 – "Encounter for…." Z codes
- Chapter 19 – Injury, poisoning, other consequences (generator changes, "underdosing" etc.) – T codes
- Chapter 4 – Endocrine, nutritional, metabolic, (DM, hyperlipidemia) – E codes
- Chapter 17 – Congenital Conditions - Q codes
- *Note: This applies to our primary diagnosis codes and is not all inclusive*

A Change of Concept?

ICD-9-CM

- 414.00 – CAD unspec.
- Or better yet…
- 414.02 Coronary atherosclerosis of autologous vein bypass graft
- **AND**
- 411.1 Intermediate coronary syndrome

ICD-10-CM

- I25.710
- Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris

It's Actually Not That Simple

- 125.111 – ASHD native coronary artery with AP with documented spasm
- 125.118 - ASHD native coronary artery with other form of angina
- 125.119 - ASHD native coronary artery with unspecified angina pectoris

All options then repeat themselves with ASHD – bypass graft

- ASHD – autologus vein graft
- ASHD – nonautologus biological graft
- ASHD – transplanted heart

Additional Information

- As a general concept if there are known risk factors for a condition – i.e. tobacco use, obesity, etc. ICD-10 instructs us to report additional information

Use Additional code to identify:

exposure to environmental tobacco smoke (Z77.22)

history of tobacco use (Z87.891)

occupational exposure to environmental tobacco smoke (Z57.31)

tobacco dependence (F17.-)

tobacco use (Z72.0)

I21 - ICD-10 STEMI and NSTEMI Myocardial Infarction

- Includes note:

  cardiac infarction

  coronary (artery) embolism

  coronary (artery) occlusion

  coronary (artery) rupture

  coronary (artery) thrombosis

  infarct of heart, myocardium, or ventricle

  myocardial infarction

  specified as acute or with a stated duration of 4 weeks or less from onset

- We also see the use additional code to specify tobacco status as before
- PLUS: "status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility (Z92.82)
- PLUS: "Use additional code, if known, to identify: body mass index (BMI) (Z68.-)

Scenario – Anterior Wall MI

I21.0 – STEMI of anterior wall – this code requires an additional character

- Options include:
- I21.01 – STEMI involving left main coronary artery
- I21.02 - ……involving left anterior descending
- I21.09 - ….. involving other coronary artery of anterior wall (various Q wave infarcts)
- This pattern continues for all wall sites
- I21.4 – Non-ST elevation MI

Manifestations Example (Note The -)

Q87.- Other specified congenital malformation syndromes affecting multiple systems

Use additional code(s) to identify all associated manifestations

Q87.4- Marfan's syndrome (must use add'l character)

Q87.40 Marfan's syndrome, unspecified

Q87.41- Marfan's syndrome with cardiovascular manifestations (must use add'l character)

Q87.410 Marfan's syndrome with aortic dilation

Q87.418 Marfan's syndrome with other cardiovascular manifestations

Q87.42 Marfan's syndrome with ocular manifestations

Q87.43 Marfan's syndrome with skeletal manifestation

Aortic Valve Disease

- In ICD-9 conditions that are not actually alike at all are represented by the same code

ICD-9:

- 424.1 Aortic Valve Disorder – includes incompetence, insufficiency, regurgitation, and stenosis

- In ICD-10 the codes are separated and actually make more sense

ICD-10:

Nonrheumatic aortic valve disorder is a "stop" code – must go on to say:

- I35.0 – stenosis
- I35.1 – insufficiency, incompetence/regurg
- I35.2 – stenosis with insufficiency
- I35.8 - Other
- I35.9 – unspecified

Valve Disease Continued

- There is a category for nonrheumatic valve disorders I34 to I37
- There are additional code options if there are also mitral and or tricuspid valve problems
- "Excludes 1 Notes" tell us the codes change if specified as congenital or rheumatic, or if multiple valves are involved
- Again we see the impact of multiple conditions reported with one code

CHF ICD-9 to ICD-10

- Little to no change here
- In both I-9 and I-10 we have options for:
- Systolic or Diastolic failure
- Acute or chronic
- Acute on Chronic

Arrhythmias

- Many direct one to one matches from ICD-9 to ICD-10
- Some additional options, and some changes in descriptions

ICD-9 – LBBB – hemiblock (left anterior & left posterior)-426.2

- 426.3 – Other LBBB (nos, complete, main stem)

ICD-10

I44.4 – Left anterior fascicular block

I44.5 – Left posterior fascicular block

I44.60 – Unspecified fascicular block – LBBB hemiblock

I44.7 – LBBB unspecified

Cerebral Infarction Example – I63.0- to I63.9

I63.0 to I63.5 – Infarct codes specific to the artery involved (right or left vertebral, R or L carotid, basilar, R or L middle , R or L anterior, posterior, cerebral etc.)

AND

Etiology per artery site:

Thrombosis, Embolism, or occlusion or stenosis

AND

We need to also report any hemiplegia or hemiparesis – right dominant, left dominant, right non-dominant etc.

AND

Dysphagia, facial weakness, ataxia etc.

? Would your documentation support this now?

Codes For Those Involved in ICD-10 Implementation

- F42 Obsessive-compulsive disorder
- Z56.3 Stressful work schedule
- Z56.6 Mental strain due to work
- Y99.0 Due to civilian activity done for income or pay
- Z73.2 Lack of relaxation and leisure
- Z72.820 Sleep deprivation

Unspecified Codes

- Contrary to what you may have heard there are still numerous conditions that have the option for continued use of an unspecified code
- I must admit that the more work I do in examining each individual condition the use of unspecified codes for some conditions is being considered as an initial implementation strategy

"Pearls" For Avoiding Implementation Pitfalls

1) Counting on another delay is NOT an implementation strategy
2) Be prepared to answer the question "Why do we need to start now?"
3) Do not limit your planning activities to just the "code" – expand your planning to include the condition itself
4) Identify top units and related top dollar conditions
5) Identify a "font" to use for systems and communications

6) Know your "X" factor and episode impact
7) Review for impact of combination codes – abbreviations, space limitations, etc.
8) Identify critical areas of Physician impact and understanding
9) Be prepared to "think outside the box", and collaborate with others as need be
10) Identify a Physician "Champion

Comments From Physician Champions

- Maintain our productivity we simply can't spend more time coding and less time with our patients
- Limit "clicks" – please don't tell me to just click 4 more places
- We can't carry around a 16 page encounter form
- We simply can not scroll through 6 feet of codes to pick one condition
- We are creatures of habit – we need time to get into a good practice
- Help coders avoid the push to a specificity of diminutive return - I.e. capillary disease – yes there are codes for that but will I ever need to be that specific?
- Simplify and clarify the training message
- Willing and want to be involved with the design of options in electronic record
- Willing to divide top condition lists and write educational articles for colleagues & develop other tools

Areas Where We Could Focus Now

- "Clean up" our problem lists - Every listed condition will eventually have to be converted to ICD-10
- Review how we are using ICD-9 now
- Review current documentation to see if it would support ICD-10 now or if changes are needed
- Identify where we can start practicing now with our top conditions? – i.e. MI by artery versus wall
- CAD – native or bypass versus unspec
- Document tobacco status on every pt
- Document BMI on every patient
- **Each one of these steps will help… and be required for ICD-10 – knock a few out early**

Sample Resources

- Go to: www.cms.gov/ICD10
- There are some VERY GOOD free tools available

- AMA – American Medical Association www.ama-assn.org/go/ICD-10
- AHIMA –American Health Information Management Association www.ahima.org
- WEDI – Workgroup for Electronic Data Interchange WWW.wedi.org
- AHA – American Hospital Association www.aha.org

Final Pearl.....

- Respect The Rattlesnake!

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