The Most Sweeping Changes & Errors in Cardiology

INDIANA CHAPTER ACC
OCTOBER 19, 2013

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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?
Why Is This A Mess?

- Direct Costs
  - Work RVU
  - Practice Expense RVU
  - Malpractice RVU

- Indirect Costs
  - Indirect PE/HR
  - Indirect %
  - Source: PPIS survey by AMA

- Direct Costs
  - Clinical Labor
  - Medical Supplies
  - Medical Equipment

Conversion Factor BN now here

Payment Rate

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
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
## 2010 PFS MD to OPPS Reimbursement

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

<table>
<thead>
<tr>
<th>Highly Clinical Codes</th>
<th>Documentation and Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The 2013 code changes are creating a challenge for many</td>
<td>• Making sure the required</td>
</tr>
<tr>
<td>“coders”</td>
<td>documentation is available</td>
</tr>
<tr>
<td>• Hospitals and some practices are fortunate enough to</td>
<td>in your note is critical</td>
</tr>
<tr>
<td>have certified and trained coders – others are not</td>
<td>• Ensuring your coders understand and recognize those components is also important</td>
</tr>
<tr>
<td>• Suggestion: Take the time to “walk through” your note</td>
<td>• If you have separated yourself from the coding process... it’s past time to reengage</td>
</tr>
<tr>
<td>with your coders and explain what measurements and</td>
<td></td>
</tr>
<tr>
<td>components support the essential elements of a code</td>
<td></td>
</tr>
</tbody>
</table>
# 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
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:
  o Improved documentation of AMI procedures
  o Name the AMI “Culprit” lesion – especially if more than one is treated
  o 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.
  o 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.
<table>
<thead>
<tr>
<th>PACEMAKER INSERTION</th>
<th>ICD INSERTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New System &amp;/or Generator + Lead</strong></td>
<td><strong>New System &amp;/or Generator + Lead</strong></td>
</tr>
<tr>
<td>__ 33206 - Single - Atrial</td>
<td>__ 33249 - Single or Dual ICD</td>
</tr>
<tr>
<td>__ 33207 - Single - Ventricular</td>
<td>__ 93641 DFT Eval Lead &amp; Generator</td>
</tr>
<tr>
<td>__ 33208 - Dual - Atrial &amp; Ventricular</td>
<td>__ 33225 LV Lead with New Generator</td>
</tr>
<tr>
<td>__ 33225 LV Lead with New Generator</td>
<td>(The above codes apply to the entire system.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GENERATOR CHANGE ONLY (no Rt lead procedure)</th>
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<tbody>
<tr>
<td><strong>Includes Generator Removal &amp; Replacement</strong></td>
<td><strong>Includes Generator Removal &amp; Replacement</strong></td>
</tr>
<tr>
<td>__ 33227 - Single, Atrial or Ventricular</td>
<td>__ 33262 - Single, Atrial or Ventricular</td>
</tr>
<tr>
<td>__ 33228 - Dual, Atrial &amp; Ventricular</td>
<td>__ 33263 - Dual, Atrial &amp; Ventricular</td>
</tr>
<tr>
<td>__ 33229 - Multi, includes LV Lead</td>
<td>__ 33264 - Multi, includes LV Lead</td>
</tr>
<tr>
<td>__ 33225 LV Lead with New Generator</td>
<td>__ 33225 LV Lead with New Generator</td>
</tr>
<tr>
<td></td>
<td>__ 93641 DFT Testing</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>GENERATOR CHANGE + R Lead Procedure</th>
<th>GENERATOR CHANGE + R Lead Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generator removal is billable, Lead removal is billable</td>
<td>Generator removal is billable, Lead removal is billable</td>
</tr>
<tr>
<td>Select “System” Code to match what was done.</td>
<td>Select “System” Code to match what was done.</td>
</tr>
<tr>
<td>__ 33206 - Single - Atrial</td>
<td>__ 33249 - Single or Dual ICD</td>
</tr>
<tr>
<td>__ 33207 - Single - Ventricular</td>
<td>__ 93641 DFT Eval Lead &amp; Generator</td>
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<td>__ 33225 LV Lead with New Generator</td>
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</tbody>
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<table>
<thead>
<tr>
<th>ADD ON SERVICES:</th>
<th>ADD ON SERVICES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>__ 33233 Generator Removal</td>
<td>__ 33241 Generator Removal</td>
</tr>
<tr>
<td>__ 33234 Remove Atrial or Ventricular Lead</td>
<td>__ 33244 Remove Atrial or Ventricular Lead (ICD)</td>
</tr>
<tr>
<td>__ 33235 Remove Dual Lead</td>
<td>__ 33234 Remove A or V lead (PM)</td>
</tr>
<tr>
<td>__ 33225 LV Lead with New Generator</td>
<td>__ 33225 LV Lead with New Generator</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INITIAL GENERATOR Attached to EXISTING LEADS</th>
<th>INITIAL GENERATOR Attached to EXISTING LEADS</th>
</tr>
</thead>
<tbody>
<tr>
<td>__ 33212 – Attached to Single (A or V) Lead</td>
<td>__ 33240 – Attached to Single (A or V) Lead</td>
</tr>
<tr>
<td>__ 33213 – Attached to Dual (A &amp; V) Lead</td>
<td>__ 33230 – Attached to Dual (A &amp; V) Lead</td>
</tr>
<tr>
<td>__ 33221 – Attached to LV Lead</td>
<td>__ 33231 – Attached to LV Lead</td>
</tr>
<tr>
<td></td>
<td>__ 93641 DFT Eval Lead &amp; Generator</td>
</tr>
<tr>
<td>“Add on” Ablation Codes</td>
<td>Separately Billable</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>“And then another arrhythmia emerged”</td>
<td>What is separately billable and what is inclusive is unique to the ablation code being submitted</td>
</tr>
<tr>
<td>Protect yourself from both lost revenue and potentially inappropriate use by making this crystal clear in your note</td>
<td>Make sure you have good tools and a solid understanding of the codes</td>
</tr>
<tr>
<td>Introductory language in CPT is a valuable educational tool all EP providers should review</td>
<td></td>
</tr>
</tbody>
</table>
**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
- 93621-26 LA Pace & Record
- 93623-26 Medication Testing
- 93609-26 Mapping
- 93613 3-D Mapping

93619 - Complete EP Study w/OUT Induction Attempt
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?

- HIPAA Transaction Codes
- NPI Numbers
- CERT Program
- MAC Conversions
- Data Centers
- RAC Program
- Private Contractors
RAC Reviews

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
The full report is available at CMS.gov/RAC

- FY 2011 – identified and corrected $939 million in improper payments

- $794 Million in overpayments
- $141 Million in underpayments
- $488.2 Million Returned to the Medicare Trust Fund
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
Demand Letter

Date

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

Re: Provider Name #123456789
Letter ID: XXXXXXX
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.
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.
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>
<thead>
<tr>
<th>CPT Code</th>
<th>You Number</th>
<th>Indiana Number</th>
<th>Difference</th>
<th>Significance*</th>
<th>Number</th>
<th>Difference</th>
<th>Significance*</th>
</tr>
</thead>
<tbody>
<tr>
<td>78452</td>
<td>108.0</td>
<td>120.6</td>
<td>-12.6</td>
<td>within the norm</td>
<td>120.4</td>
<td>-12.4</td>
<td>lower</td>
</tr>
<tr>
<td>93015</td>
<td>108.0</td>
<td>98.8</td>
<td>9.2</td>
<td>within the norm</td>
<td>97.8</td>
<td>10.2</td>
<td>higher</td>
</tr>
<tr>
<td>93306</td>
<td>254.0</td>
<td>104.4</td>
<td>149.6</td>
<td>higher</td>
<td>149.7</td>
<td>104.3</td>
<td>higher</td>
</tr>
<tr>
<td>93880</td>
<td>N/A</td>
<td>60.5</td>
<td>N/A</td>
<td>N/A</td>
<td>70.9</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
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.
Never underestimate the power of your pen.
In Case You Are Wondering....

This is NOT the correct response
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1)</strong></td>
<td><strong>Less than 10 systems in a ROS when a comprehensive history is required</strong></td>
</tr>
<tr>
<td><strong>2)</strong></td>
<td><strong>Missing a family or social history when a comprehensive history is required</strong></td>
</tr>
<tr>
<td><strong>3)</strong></td>
<td><strong>Billing at a high level of medical decision making when the code is better as a moderate</strong></td>
</tr>
<tr>
<td><strong>4)</strong></td>
<td><strong>Not having the required exam elements on a hospital level 3 follow-up visit</strong></td>
</tr>
<tr>
<td><strong>5)</strong></td>
<td><strong>Problems with “incident to” (office setting) documentation</strong></td>
</tr>
<tr>
<td><strong>6)</strong></td>
<td><strong>Problems with ”split/shared” visit documentation in the hospital setting</strong></td>
</tr>
<tr>
<td><strong>7)</strong></td>
<td><strong>Visit does not clearly identify a “significant and separate” condition on the day of a procedure or within a global period</strong></td>
</tr>
<tr>
<td><strong>8)</strong></td>
<td><strong>Not clearly documenting the consultation request when the consult code is billed</strong></td>
</tr>
<tr>
<td><strong>9)</strong></td>
<td><strong>Conflicting information in the HPI versus the ROS with electronic medical records</strong></td>
</tr>
<tr>
<td><strong>10)</strong></td>
<td><strong>Not clearly documenting the patient’s “new pt” status</strong></td>
</tr>
</tbody>
</table>
• 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
One More Comment.....
ICD-10 Implementation
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
<table>
<thead>
<tr>
<th>MEDICAL CONDITION</th>
<th>EPISODES</th>
<th>TOTAL</th>
<th>PROFESSIONAL</th>
<th>MEDICAL/SURGICAL</th>
<th>ANCILLARY</th>
<th>HOSPITAL INPATIENT</th>
<th>INPATIENT PROFESSIONAL</th>
<th>PHARMACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic Heart Disease - SOI 1</td>
<td>33</td>
<td>7,276</td>
<td>2,087</td>
<td>218</td>
<td>177</td>
<td>833</td>
<td>71</td>
<td>3,228</td>
</tr>
<tr>
<td>Acute Myocardial Infarct, Active - SOI 1</td>
<td>1</td>
<td>38,660</td>
<td>23,456</td>
<td>78</td>
<td>264</td>
<td>0</td>
<td>72</td>
<td>35,876</td>
</tr>
<tr>
<td>Hypertension - SOI 1</td>
<td>3</td>
<td>448</td>
<td>654</td>
<td>141</td>
<td>134</td>
<td>0</td>
<td>2</td>
<td>190</td>
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<tr>
<td>Ischemic Heart Disease - SOI 2</td>
<td>4</td>
<td>14,259</td>
<td>6,650</td>
<td>400</td>
<td>227</td>
<td>233</td>
<td>171</td>
<td>9,612</td>
</tr>
<tr>
<td>Diabetes with Circulatory - SOI 1</td>
<td>13</td>
<td>9,707</td>
<td>4,965</td>
<td>374</td>
<td>370</td>
<td>5,054</td>
<td>317</td>
<td>3,182</td>
</tr>
<tr>
<td>Diabetes with Circulatory - SOI 2</td>
<td>1</td>
<td>23,948</td>
<td>17,351</td>
<td>403</td>
<td>540</td>
<td>14,701</td>
<td>658</td>
<td>6,018</td>
</tr>
<tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Aexcel-Designated Specialists</td>
<td>Non-Designated In-Network Specialists</td>
<td>Other Specialists (outside the 12 Aexcel specialty areas)</td>
<td>Out-of-Network Specialists</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------------</td>
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<td>----------------------------------------------------------</td>
<td>----------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Aetna PPO with Aexcel</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>90%</td>
<td>80%</td>
<td>90%</td>
<td>70%</td>
<td></td>
<td></td>
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<tr>
<td><strong>Deductible</strong> (Employee Only)</td>
<td>$250</td>
<td>$250</td>
<td>$250</td>
<td>$250</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coinsurance Limit</strong> (Employee Only)</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$2,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialists Copay/Coinsurance</strong></td>
<td>$15</td>
<td>$30</td>
<td>$30</td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Aetna EPO with Aexcel** |                                |                                       |                                                          |                            |
| **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                |
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
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?

<table>
<thead>
<tr>
<th>Nation</th>
<th>Size of Code Set</th>
<th>Clinical Setting For Use</th>
<th>Funding to Providers</th>
<th>Pilot Testing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States ICD-10-CM</td>
<td>68,000</td>
<td>Inpatient and outpatient</td>
<td>None</td>
<td>No</td>
</tr>
<tr>
<td>Australia ICD-10 AU</td>
<td>22,000</td>
<td>Inpatient only</td>
<td>Government</td>
<td>Yes</td>
</tr>
<tr>
<td>Canada ICD-10 CA</td>
<td>17,000</td>
<td>Inpatient only</td>
<td>Government</td>
<td>Yes</td>
</tr>
<tr>
<td>Germany ICD-10-GM</td>
<td>13,300</td>
<td>Inpatient and outpatient</td>
<td>Government</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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...

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10-CM</td>
<td>ICD-10-PC</td>
</tr>
<tr>
<td>Hosp and Physicians</td>
<td>Hosp only</td>
</tr>
<tr>
<td>ICD-9 14,315</td>
<td>ICD-9 3,838</td>
</tr>
<tr>
<td>ICD-10 69,099</td>
<td>ICD-10 71,957</td>
</tr>
</tbody>
</table>
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
In little teeny, tiny print

- If measured with a ruler:
  - CAD: 6 inches to 6 feet
  - CVP: 3.7 feet to 19 feet
  - DM: 1.8 feet to 6.8 feet
Number of Characters – 3-7

category

etiology, anatomic site, manifestation

category

etiology, anatomic site, severity

extension
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, o, I, 1
- Times new roman – O, 0, I, 1
- Consolas – 0, 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
• 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 5\textsuperscript{th} or 6\textsuperscript{th} position for example so that you can still provide the information represented by the 6\textsuperscript{th} and/or 7\textsuperscript{th} 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
| I70.21 – Atherosclerosis of native arteries of extremities with intermittent claudication | M79.60 Pain in limb unspecified |
| 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 |
| 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?

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>414.00 – CAD unspec.</td>
<td>I25.710</td>
</tr>
<tr>
<td>Or better yet...</td>
<td>Atherosclerosis of autologous vein coronary artery bypass graft(s) with unstable angina pectoris</td>
</tr>
<tr>
<td>414.02 Coronary atherosclerosis of autologous vein bypass graft</td>
<td></td>
</tr>
<tr>
<td>AND</td>
<td></td>
</tr>
<tr>
<td>411.1 Intermediate coronary syndrome</td>
<td></td>
</tr>
</tbody>
</table>
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
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)
- 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
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
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.
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
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.
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Counting on another delay is NOT an implementation strategy</td>
</tr>
<tr>
<td>2</td>
<td>Be prepared to answer the question “Why do we need to start now?”</td>
</tr>
<tr>
<td>3</td>
<td>Do not limit your planning activities to just the “code” – expand your planning to include the condition itself</td>
</tr>
<tr>
<td>4</td>
<td>Identify top units and related top dollar conditions</td>
</tr>
<tr>
<td>5</td>
<td>Identify a “font” to use for systems and communications</td>
</tr>
<tr>
<td>6</td>
<td>Know your “X” factor and episode impact</td>
</tr>
<tr>
<td>7</td>
<td>Review for impact of combination codes – abbreviations, space limitations, etc.</td>
</tr>
<tr>
<td>8</td>
<td>Identify critical areas of Physician impact and understanding</td>
</tr>
<tr>
<td>9</td>
<td>Be prepared to “think outside the box”, and collaborate with others as need be</td>
</tr>
<tr>
<td>10</td>
<td>Identify a Physician “Champion”</td>
</tr>
</tbody>
</table>
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!
- Lggates@stvincent.org