ICD-10 Delayed- Keep Moving Forward
By Laura Legg, RHIT, CCS

Momentum is the forward movement of a driving power or strength. One of the qualities of momentum is that it is likely to continue. Any of us who have experienced momentum as it relates to a project or complex undertaking know it to be a good thing. Momentum can take us a long way and get us where we need to be when we need to be there. Despite obstacles, good momentum just keeps moving forward.

ICD-10 implementation is without a doubt a complex undertaking. To convert a complex healthcare system to a new coding system is a challenge. Many providers, individuals and others have in good faith gone forward and created the necessary momentum to support the implementation of ICD-10 CM by the goal date of October 1, 2013.

On February 15, 2012, HHS announced intent to delay ICD-10 compliance date. The statement did not contain any indication of a new deadline or when the rulemaking process would begin. CMS stated they will reexamine the timeline with an eye to lessening the burden on physicians. The AMA recently sent letters to Congress calling for a halt to the ICD-10 implementation. The AMA cited high workload in responding to current federal initiatives, including meaningful use.

The CMS announcement to pursue a delay was met with mixed reactions. The AHIMA immediately expressed concern over the confusion this statement caused. The AHIMA fears that mixed signals sent by the announcement could cause the healthcare community to delay and lose the momentum that is currently driving us forward.

Many national goals, such as electronic health records, quality initiatives and information exchange are dependent on a 21st century classification system. A great deal of energy and resources have been invested in ICD-10 and no one wants this progress and investment lost.

As CMS “reexamines the pace” and “the rulemaking takes place” and the “final posting” could take months many of us want to keep moving forward. In the interest of the advancement of healthcare in the US, hospitals and healthcare systems must continue along their ICD-10 transition path and not get derailed. We know the reasons are endless (see the AHIMA “Top Ten Reasons We Need ICD-10 Now” on the AHIMA ICD-10 Webpage). The resources are out there and the people we care for are waiting so let’s keep the momentum moving forward!

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The April 1st deadline is looming.....

CMS postponed the original January 1, 2012 enforcement date giving organizations a 90-day discretionary period until April 1, 2012 to be compliant with Version 5010.

By now practices should have an implementation plan in place. This plan should include information on how 5010/ICD-10 will impact your company as well as a detailed timeline and budget. You should know that your software vendor, clearinghouse and billing services are compliant and should already be transmitting Version 5010 claims. If they are not submitting Version 5010 claims will they be able to do so before the April 1st deadline?

Any claims received after April 1, 2012 not submitted as Version 5010 will not be paid.

Version 5010 is a necessary upgrade on the road to ICD-10 and does offer several enhancements over the current Version 4010. However, unlike the possible postponement of ICD-10 CMS has not indicated it will continue to delay the requirement of Version 5010.

A few of the benefits of the transition to Version 5010 include:

- Increases the field size for ICD codes from 5 to 7 bytes allowing for the transition to ICD-10.
- Increases the number of diagnosis codes allowed on a claim.
- Distinguishes principal diagnosis, admitting diagnosis, external cause of injury and patient reason for visit codes.

CMS has many 5010/ICD-10 resources available to help providers on their website at: http://www.cms.gov/ICD10/

**Monique Vanderhoof, CPC**

Monique Vanderhoof, CPC joined RMC in September 2011 as Manager of HCC Services...focusing on HCC coding audits and client education. With over 15 years experience as a Clinic Manager Monique has a extensive experience working in both outpatient and inpatient physician billing with emphasis in cardiology. Her skills also include EHR implementation, HIPPA, eRx and Meaningful Use readiness and attestation.

Following the HHS announcement of intent to delay the ICD-10 compliance date the question has been asked if the US should just wait and go straight to ICD-11. Getting any specific information on ICD-11 right now is difficult. The World Health Organization website tells you that the international classification of diseases 11th revision is due by 2015. There are some links available from there but they really don’t take you anywhere to actually see any detail about ICD-11. Leading experts are telling us that ICD-10 is the pathway to ICD-11 so building ICD-11 without ICD-10 would be like building the fifth floor of a building before building the foundation.

Another point made is that ICD-11 cannot be implemented “off the shelf”. It has taken 8 years to get ICD-10 ready for implementation in the US and although ICD-11 would probably not take that much time it is still a lengthy task. 2015 is the year that ICD-11 will be available for use by the World Health Organization not for use in the US.

We need an updated classification system now. The AHIMA has done an excellent outline of why in their recent release of “Ten for 10- The top ten reasons we need ICD-10 now. “ The HHS has brought forth a lot of initiatives for the healthcare community to comply with and ICD-10 is an important part of meeting those initiatives. HHS’ initiatives range all the way from financial initiatives to patient safety and quality of patient care.

Why would the United States want to remain so far behind the rest of the world? Must we be dragged kicking and screaming to catch up everyone else? Bottom line: We can’t wait for ICD-11 because we have too much at stake.
RAC UPDATES WITH RMC

HOSPITAL RAC ACTIVITY

DRG Validation claims for 4th Q 2011
The purpose of MS-DRG validation is to determine that the principal diagnosis and all secondary diagnoses identified as CCs and MCCs are actually present, correctly sequenced, coded and clinically validated. When a patient is admitted to the hospital, the condition established after study found to be chiefly responsible for occasioning the admission to the hospital should be sequenced as the principal diagnosis. The other diagnosis identified should represent all (MCC/CC) present during the admission that impact the stay. The POA indicator for all diagnoses reported must be coded correctly. New issues for 4th Q 2011 are:

CGI added four new issues for DRG validation claims to its CMS-approved list for providers in all Region B states.

- Nutritional disorders.
- Excisional debridement.
- Disorders of pituitary gland and hypothalamic control.
- Acute kidney failure.

Connolly Healthcare added three new issues across two categories—two for medical necessity claims and one for DRG validation claims—to its CMS-approved list for providers in all Region C states.

- Bone marrow transplant: MS-DRG 014 and 015 [Previously DRG 009].


- MS-DRG validation for MS-DRG 570, 571 and 572 skin debridement.
- MS-DRG validation for MS-DRG 016 and 017 autologous bone marrow transplant.

CMS Transfers Demand Letter Responsibility from RACs to MACs

The Centers for Medicare and Medicaid Services (CMS) recently announced that Medicare’s recovery audit contractors (RACs) will no longer issue demand letters to providers as of January 3, 2012. CMS is transferring the responsibility to Medicare administrative contractors (MACs), who will perform the adjustments based on the RAC’s review and issue an automated demand letter. MACs will then be responsible for fielding any administrative concerns providers may have such as timeframes for payment recovery and the appeals process.

Best Practice-RAC What to implement now!

Admit orders- Do you have a policy that describes what your admit orders should look like and the language they need to contain? If not, you need one. Auditors are looking for specific language in physician’s admitting orders that specify the level of care.

Utilization review- Are there case managers reviewing all of your admits to be sure they meet the criteria of admission?

Clinical documentation improvement - Do you have a dynamic CDI program? CDI teams should be making documentation recommendations that will support your admission.

Audits-Self auditing is essential to verify the necessity of an admission and to identify potential RAC denial vulnerabilities.

Continued on following page...
Physician/Non-Physician Practitioner Issues-RAC ACTIVITY

Two of the Recovery Audit Contractors posted new issues for professional services in the last quarter of 2011. All new issues that are identified must first be approved by CMS. Once CMS approves an issue for review, the RAC places the issue on their website prior to any provider communications. Providers should regularly check their RAC region websites for new issue updates.

DCS Healthcare Services – Medicare RAC Region A
Failure to Correctly Bill Codes on the Medically Unlikely Edit List for Practitioner Services - Posted 12/07/11
Certain codes on the MUE list are being incorrectly billed. An error was made in billing these codes, because more units were billed for same date of service for the same beneficiary by the same provider than what is medically likely and an appropriate modifier was not appended to the claim line. Claims having a “claim paid date” which is more than 3 years prior to the ADR date will be excluded.

HealthDataInsights (HDI), Medicare RAC Region D
Transforaminal Epidural Injection Billed with Guidance
Per CPT Manual 2011, CPT Codes 77001-77003 and 77012, are not to be reported with CPT Codes 64479, 64480, 64483 and 64484. Effective for claims that have a “claim paid date” which is less than 3 years prior to

Avoid Future Payment Reductions by Submitting your eRx Claims Now
Monique Vanderhoof, CPC

Some providers may already be feeling a pinch from a 1% reduction in Medicare payments this year because they didn’t successfully submit claims for the eRx program in 2011. This reduction is set to increase to 1.5% for 2013 and to some practices these small percentages translate to thousands of dollars in lost revenue.

Why so much money?

Because the eRx reduction is taken from ALL Medicare Part B services provided for the following year. Not just those that would have qualified as eRx claims. So, if you did not submit eRx claims successfully in 2011 all of your Medicare Part B claims for services rendered January 1, 2012-December 31, 2012 are subject to the 1% reduction. The increased percentage for 2013 will follow this same rule.

Many providers were caught thinking they did not have to participate in the eRx program because they chose to participate in the Meaningful Use incentive program. Not true! All providers must still submit claims for eRx to avoid the penalty. Providers that participate in both programs will only receive incentive payments from the program with the highest incentive payout. You cannot receive incentive payment for both but you MUST participate.

The good news is you still have time to get your claims in this year to avoid the 2013 payment reduction.

Providers who did not successfully participate in last year’s program need to submit a minimum of 10 incentive eligible claims for services provided January 1, 2012-June 30, 2012. The eligible office visit codes are: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109.

Those claims will need to be processed before July 29, 2012 to be considered in the program so be sure to watch your remittance advice to ensure that the claim was successfully processed. CMS is using specific remittance advice codes so that you can ensure successful acceptance for the incentive program.

For more information on these remittance advice codes or additional information on the eRx incentive program visit www.cms.gov/erxincentive.
What is the best ICD-9 diagnosis code for an elevated D-dimer test?

Jane Barta, RHIA

To answer this question, first let’s define a D-Dimer test. According to the University of Texas Medical Branch Laboratory Test Directory, the D-dimer test detects elevated levels of cross-linked fibrin derivatives. Fibrin is an insoluble protein that is essential to the process of blood clotting. In very simple terms, D-dimer tests show the quantity of fragments (remnants) of blood clotting processes. High levels of these cross-linked fibrin derivates (dextro-dimer fragments) are associated with disseminated intravascular coagulations (DIC), deep vein thrombosis, pulmonary embolism, and other thrombotic conditions. Elevated D-dimer test results have also been reported in the postoperative period, and with various cancers, hemorrhages or a severe infection.

A D-dimer level is used to help diagnose the above conditions and may also be used to monitor the effectiveness of DIC treatment. According to labtestsonline.org, D-dimer concentrations may rise in the elderly and false positives may be seen with high levels of rheumatoid factor, a protein seen in patients with rheumatoid arthritis. High triglycerides, lipemia and bilirubin can also cause false positive as can hemolysis caused by improper sample collection and handling.

Currently there is no official determination as to the best code for this test. 790.6, other abnormal blood chemistry, relates to chemicals/elements in the blood such as cobalt, copper, iron or lead and thus does not apply. Some coders like 790.92, abnormal coagulation profile. However, the D-dimer test looks for the breakdown of clots (fragments), rather than coagulation. Therefore, 790.99, other nonspecific findings on examination of blood, is the current code that best describes this condition.
Thanks to hindsight being 20/20, we have some idea of what to expect this year for healthcare data. The Ponemon Institute’s 2011 Benchmark Study on Patient Privacy and Data Security found a rise of 32% in data breaches (surveyed healthcare organizations) costing the industry an average of $6.5 billion. According to summations in an ID Experts press release, this bodes ill for organizations that don’t treat protection of PHI as a patient safety issue. With more mobile device use and the OCR coming down hard on privacy violations, some experts say that healthcare data breaches “risk reaching epidemic proportions” in 2012.

The Study’s predictions for healthcare data primarily focus on dire results if healthcare organizations and their business associates do not take the necessary steps to protect PHI. As I’ve said before and will undoubtedly say again, data breach risks stem primarily from the human factor, less from the technology side.

I do feel, as quoted in the press release, that social media risks in healthcare will grow. Social media is a handy tool and more providers are using it both as a patient communication tool and as a service promotion tool. Again, though, this risk to PHI derives as much from lack of a social media use plan for employees to follow as it does from the technology itself. Good workforce training on what should never appear on a social network page can help an organization avoid the risks that lead to patient vulnerabilities, data breaches, civil penalties, loss of business and more.

The press release quotes the concerns of many colleagues in the healthcare industry. Overall, we see 2012 as holding the potential for increased risks to healthcare data, mainly due to lack of security and privacy policies and best practices.

- High-dollar, class-action lawsuits will increase as outraged patients turn to the courts for satisfaction for harm after data breaches. In turn, the responsible provider loses not only money, but also reputation.
- Business Associate relationships and agreements bear hard examination. Forty-six percent of data breaches reported are due to third-party mistakes, and 69% of Ponemon study participants have “little or no confidence” in their BAs.
- Cyber liability insurance will become a must for providers and other healthcare organizations as they strengthen their data breach response plans. It will also become more likely as providers using HIE work with Cloud computing vendors who face liability risks in their business associate role.
- Education and training (annual privacy and security sessions) will gain greater importance as organizations strive to offset the human impact on data safety. It will also gain attention in the business and consumer sector to prevent the rise in fraud that typically accompanies tough economic times.
- 2012 will be the year of focus on the 150 OCR HIPAA audits, plus the aggressive attention and enforcement of “willful neglect” penalizations.

“An ounce of prevention is worth a pound of cure.” Ben Franklin’s words are as true in regard to healthcare data protection as to any safety precaution. With the correct risk mitigation, the mostly grim 2012 predictions about our healthcare data privacy and security could be avoided.

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When an inpatient medical record has incomplete, inconsistent, unclear, or ambiguous documentation for assigning ICD-9-CM diagnoses or procedure codes, a physician query is recommended. The query may be sent concurrently or retrospectively by the clinical documentation improvement specialist (CDI) or by a coder. It is important to have a specific query form that the facility uses along with condition-specific query forms. “Sticky notes,” scrap paper, or other miscellaneous forms for query should never be used as a query. Establishing a method for incorporating the query information into the medical record is highly recommended.

As a result of the disparity in documentation practices by providers, querying has become a common communication and educational method to advocate proper documentation practices. Queries may be made in situations such as the following:

- Clinical indicators of a diagnosis but no documentation of the condition
- Clinical evidence for a higher degree of specificity or severity
- A cause-and-effect relationship between two conditions or organism
- An underlying cause when admitted with symptoms
- Only the treatment is documented (without a diagnosis documented)
- Present on admission (POA) indicator status

It is necessary and proper to query providers whenever there is conflicting, ambiguous, or incomplete information in the health record regarding any significant reportable condition or procedure. Healthcare facilities might consider a policy in which queries would be appropriate when documentation in the patient’s record failed to meet one of the following five criteria: legibility, completeness, clarity, consistency, or precision.

Reasons facilities would want to take the time to track queries would be to:

- Facilitate support of documentation improvement efforts
- Monitor release of the claims for billing purposes
- Assess timeliness of query process
- Improve the query process
- Improve the coding process
- Improve the documentation
- Educate the physicians, coding staff, and other clinical staff

When monitoring the queries the reviewers should be looking for problems in the implementation and use of queries that need modification or improvements such as if physicians are being queried frequently, investigate the reasons for the queries.

First question is what the facility might consider auditing their queries for evidence of:

- Leading queries
- Timeliness
- Unnecessary queries
- Poor choice of wording/clarity
- Missed query opportunities
- Noncompliance with query standards (AHIMA or internal policies and procedures)
- Inclusion of clinical indicators
- Inaccurate information on the query form
- Physician agreement from individual coders or CDIs
- Focus of queries (CC/MCC, principal diagnosis, procedure, SOI/ROM, etc.)
- Rate of queries to individual physicians/group of physicians (surgeons, cardiologists, etc)
- Method of queries (verbal or written)/(concurrent/retrospective)

Healthcare facilities should establish procedures for auditing and monitoring their query process using the information collected for physician and staff education along with improving the query process. Queries would be reviewed retrospectively to ensure that they are completed according to documented policies. Review of the query would reveal
if query was necessary, if language in the query was not leading or inappropriate, and if the query did not introduce new information that was not in the health record.

Based on the results of this review, the healthcare facility may need to identify follow-up actions. For example, cases identified as inappropriate queries resulting in inaccurate code assignment will require that codes be corrected at the level supported by the documentation without the leading query. Any DRG changes would need to be address at this time and any necessary follow-up would need to be done. Inappropriate queries should be tracked and trended, followed by appropriate education and training.

In order for the query process to be effective, auditing and monitoring should be conducted on a regular basis. This process can include a representative sample of total queries as well as a sampling by individuals initiating the query. Effective elements of an auditing and monitoring program include:

- Auditing for percentage of negative and positive provider responses. A high negative response rate may indicate overuse of the query by the coding staff; a high positive response rate may indicate a pattern of incomplete documentation that needs further investigation.
- Auditing the format of query forms. Discovery of inappropriate query formats can be used as an educational tool for coding staff.
- Auditing of individual providers to indicate improvement in health record documentation. Improvement in documentation should result in a decreased number of queries for an individual provider.
- Auditing of high-risk or problem diagnoses. The results may determine whether additional education resulted in a decreased number of queries for a particular diagnosis.

Auditing and monitoring programs should establish the data fields to be collected and reported. When reviewing both performance measures and compliance monitors, the errors related to documentation will become apparent.

Consideration might be given to designing quality improvement projects related to physician queries to provide feedback on the query process by:

- Looking for patterns of queries (i.e., are there repeated queries on the same topic, such as anemia or pneumonia?) and plan to educate coders and physicians on the query process and documentation issues.
- Reviewing responses to the query to reveal discerning use by the coding staff and/or poor physician documentation practices. This review can also reveal whether necessary reports (discharge summary, operative report) are included in the medical record before coding.

To develop consistency, consider testing reliability between coders by using blinded checks by different coders to see whether the same codes and queries are generated. Healthcare facilities should have a process in place to support and educate the staff involved in conducting provider queries. Ongoing education and training is a key component of the auditing and monitoring process.

Reference: AHIMA Managing an Effective Query Process
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