ICD-10 For Radiology – Post Implementation Strategies

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Agenda

- ICD-10 Review
- Documentation Concepts
- Impact to Radiologists
- Risks and Challenges
  - Documentation
  - Revenue cycle operations
- Metrics
- Resources
- Questions
Let’s Revisit Requirements

ICD-10-CM
- Increased number of diagnosis codes
- Expands to a longer code and uses both numbers and letters
- Much greater specificity in each code
- Must be used for coding services delivered Oct 1, 2015 and after

ICD-10-PCS
- This classification system was developed by the Centers for Medicare and Medicaid Services for us in the US inpatient hospital setting only
The Alphabetic Index and Tabular List

- The ICD-10-CM is divided into the Alphabetic Index, an alphabetical list of terms and their corresponding code, and consists of the following parts: the Index of Diseases and Injury, the Index of External Causes of Injury, the Table of Neoplasms and the Table of Drugs and Chemicals.

- Tabular List, is a structured list of codes divided into chapters based on body system or condition.

- There are 21 chapters and all ICD-10-CM codes begin with alpha character.
Structural Differences in ICD-10-CM

ICD-9 Code Format

Category
Etiology, Anatomic site, Manifestation

ICD-10 Code Format

Category
Etiology, Anatomic site, Manifestation
Extension
Official Guidelines

Cooperating parties

- CMS
- CDC
- AHA
- AHIMA

- Official Guidelines Posted to CDC website
This is isn’t About Coding – It’s About Documentation Concepts

1. Laterality
2. Anatomy
3. Episode of Care
4. Etiology
5. Acuity
Trauma/Injury

- Episode of Care
- Anatomic Location
- Laterality/Upper Lower
- Geographic Location
- How
- Intent
- Status
Alpha Extensions: Injuries

- a initial encounter for closed fracture
- b initial encounter for open fracture
- d subsequent encounter fracture w/routine healing
- g subsequent encounter fracture w/delayed healing
- j subsequent encounter for fracture with nonunion
- q sequela (late effect)

Subsequent care definition is edited and adds wording that includes “an X-ray to check on healing of a fracture” to the current Coding Guideline examples.
**Bilateral Diagnosis Codes**

- Frequent in eye, ear, MS, vascular, and injury

- For some, right, left, bilateral, unspecified; for some, right, left, unspecified

- Your CPT code will still require modifier 50 for bilateral, or RT/LT even if diagnosis code states right, left, or bilateral
External Cause Codes

Greatly expanded

- Equivalent of E codes
- Watch for denials or claim slow downs
- Optional—payer driven
Example: Limb Pain

Document the specific limb and laterality.

- M79.60 – M79.609 – arm or leg and left or right
- M79.62 – M79.639 – upper arm or forearm, left or right
- M79.64 – M79.646 – hand or fingers, left or right
- M79.65 – M79.669 – thigh or lower leg, left or right
- M79.67 – M79.676 – foot and toes, left or right
Documentation Issues

- **Physician readiness is key**
  - This requirement is more vital for imaging, educating radiologists & referring providers to provide the level of detail, severity and context of the patient’s condition

- **Clinical statements are vital to receiving reimbursement**
  - For radiology services, it’s not always clear how the imaging procedure performed relates to the patient’s condition

- **Imaging leaders need to minimize the number of unspecified codes coming into your practice**
When to use Signs and Symptoms?

- When findings are negative or normal use the signs or symptoms that prompted the ordering of the test.
- Radiologists and Pathologists code their definitive finding first, but if no pathology is found, they are required to code the clinician’s reason for ordering the radiology or pathology test.
- Coders can report a sign or symptom as a principal diagnosis when:
  - The etiology of the sign or symptom is unknown at the time of discharge.
  - The sign or symptom is due to an unsubstantiated contrasting or comparative etiology at the time of discharge.
  - The sign or symptom is due to the adverse effect of a drug.
Risk & Challenges
Referring Physicians Impact to Radiology

- Heavily dependent on other healthcare professionals for clinical data
- Capturing new information about the patient’s condition and more detailed diagnosis information from referring physician orders will be a particular challenge
- Precertification/preauthorization
- If you have not already done so, plan to contact your high volume referring physicians and work extensively with them to operationalize ICD-10-CM
- You need to incorporate that detail into your interpretive report and the patient’s medical record. For example, the coding for injuries such as fractures.
- Failure of referring physicians to supply this information may cause delayed or lost reimbursement to the radiologist
Telehealth Impact

- Teleradiology is not expected to go away, and may even grow, or at least change, in the next few years.
- There are no new or additional requirements as a result of ICD-10 code sets.
- Teleradiology groups are covered entities under the HIPAA privacy and security rules.
Flexibility Rule

- The American Medical Association (AMA) and Center for Medicare and Medicaid Services (CMS) were able to work on a set of grace period rules that will ease the transition to ICD-10 and reduce the financial risk.
- Claim denials: For the first year ICD-10 is in place, Medicare claims will not be denied solely based on the specificity of the diagnosis codes as long as they are from the appropriate family of ICD-10 codes.

One-year Grace Period Aids ICD-10 Transition

- Payment disruptions: If Medicare contractors are unable to process claims as a result of problems with ICD-10, CMS will authorize advance payments to physicians.

- Navigating transition problems: CMS has said it will establish a communication center to monitor issues and resolve them as quickly as possible. This will include an “ICD-10 ombudsman” devoted to triaging physician issues.
What is a valid ICD-10 code?

- Only for fee-for-service Medicare, not Medicare Advantage, Medicaid, or commercial payers
- Valid, within the family- clarified to category
- One year grace period for unspecified codes
- Payer policies and reimbursement policies haven’t changed. Must still meet NCD/LCD requirements

**Tip**

Non-specific codes are still available for use when medical record documentation does not support a more specific code.

*Per the 837 Rule you can bill 4 diagnosis codes per procedure (line item)*


Billable and non-billable codes

- ICD-10-CM codes with red arrows are not billable and contain child codes with greater level of specificity
- ICD-10-CM codes with green arrows are specific and billable

http://www.icd10data.com/ICD10CM/Codes/M00-M99/M70-M79/M79-/M79.60
MEASURING ICD-10 PERFORMANCE

TOP METRICS TO MONITOR
Portable x-ray equipment—Supplier compliance with transportation and setup fee requirements

We will review Medicare payments for portable x-ray equipment services to determine whether payments were correct and were supported by documentation. We will also assess the qualifications of the technologists who performed the services. Prior OIG work found that Medicare may have improperly paid portable x-ray suppliers for return trips to nursing facilities (i.e., multiple trips to a facility in 1 day). Medicare generally reimburses for portable x-ray services if the conditions for coverage are met. (42 CFR §§ 486.100–486.110.) (OAS; W-00-14-35464; various reviews; expected issue date: FY 2015)

Diagnostic radiology—Medical necessity of high-cost tests

We will review Medicare payments for high-cost diagnostic radiology tests to determine whether the tests were medically necessary and to determine the extent to which use has increased for these tests. Medicare will not pay for items or services that are not “reasonable and necessary.” (Social
Are You Relying on Mapping?

- Unspecified because the ICD-9 code was unspecified
- Or, ICD-9 code was as specific as possible but there are more options in ICD-10
- Review problems in problem list
- Check all mapped codes
- Run a frequency report, identify unspecified codes
- Educate, educate, educate
Payer Edit Strategy

- Claims submitted for DOS 9/30/15 use ICD-9
- Claims submitted for DOS 10/1/15 and later use ICD-10
- Cannot submit ICD-9 and ICD-10 on the same claim

Example Edit

ICD-10-CM Laterality Edits - BCBSKS only

The following edits will be implemented for BCBSKS (47163) only, and will begin with the acceptance of ICD-10-CM coding on 10/1/2015.

PURPOSE: EDI front end edits for Professional, Institutional and Dental claims will be implemented to encourage providers to document and specify the most appropriate code related to a condition. Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the right, left, or is bilateral. If a claim is received with an unspecified code, the claim will reject. You will need to check with the provider to determine which side(s) were affected and submit the claim with the specific code. Accurate coding allows BCBSKS to administer policy benefits in an efficient and effective manner.

Payers Exempt from ICD-10

Not required to transition to ICD-10, because not a HIPAA covered entity

Property & Casualty differences:

- Exempt from the HIPAA regulations
- Governed by state law rather than federal regulations
- Adoption of new code sets, such as ICD-10 may require rule making prior to enactment

Denial Management

- The payers reimbursement rules are not changing
- The basics of diagnosis coding aren’t changing
- Do you track denials by reason code now?
- Do you give feedback to front desk staff, coders, billers and clinicians now?
- Do you have a baseline of current denials?
ICD-10 Transition Moves Forward

CMS is continuing its vigilant monitoring process of the ICD-10 transition and can share the following metrics detailing Medicare Fee-for-Service claims from 10/1-10/27.

<table>
<thead>
<tr>
<th>Metrics</th>
<th>October 1-27</th>
<th>Historical Baseline*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Claims Submitted</td>
<td>4.6 million per day</td>
<td>4.6 million per day</td>
</tr>
<tr>
<td>Total Claims Rejected due to incomplete or invalid information</td>
<td>2.0% of total claims submitted</td>
<td>2.0% of total claims submitted</td>
</tr>
<tr>
<td>Total Claims Rejected due to invalid ICD-10 codes</td>
<td>0.09% of total claims submitted</td>
<td>0.17% of total claims submitted</td>
</tr>
<tr>
<td>Total Claims Rejected due to invalid ICD-9 codes</td>
<td>0.11% of total claims submitted</td>
<td>0.17% of total claims submitted</td>
</tr>
<tr>
<td>Total Claims Denied</td>
<td>10.1% of total claims processed</td>
<td>10% of total claims processed</td>
</tr>
</tbody>
</table>

NOTE: Metrics for total ICD-9 and ICD-10 claims rejections were estimated based on end-to-end testing conducted in 2015 since CMS has not historically collected this data. Other metrics are based on historical claims submissions.
Clearinghouse Reports

- Claims rejected by clearinghouse
- Claims rejected by the payer
- Review promptly
- Do you have access to a report of denials by diagnosis code now? Or procedure code?
- What is the root cause of these denials?
Reason Codes Related to Diagnosis

Not all denials will be related to ICD-10

- Look at CARC (claims adjustment reason codes)
- And, RARC (remittance advice remark codes)
- Available at: http://www.wpc-edi.com/reference/
Denial Response Management

- Find and review NCDs, LCDs and private payer policies for services with denials
- Denial percentage by payer, line item, claim, type of service
- Frequency of claims rejected or suspended by clearinghouse, and reason
- Volume and dollar value of denials by reason
- Coding denials routed to coders
- All diagnosis related denials reviewed with manager and radiology leader
- No batching for later
- Establish time thresholds for review/resubmission
Financial Metrics

- 80/20 payer analysis
- A/R days (by payer)
- Cash flow
- Claims paid on first pass
- Denial statistics including numbers & percentages for various time periods overall and by reason codes
- Revenue by modality if appropriate
Action Steps

- Determine your key metrics in each area
  - Examine current reporting systems to determine what you already know
    - Set up reporting channels
  - Be prepared to quickly adjust workflows
  - Have contingency plans
Monitoring

- Continue to work closely with providers regarding the changes from ICD-9-CM to ICD-10-CM
- Evaluate the use of your PACS for documentation specific changes that will need to be made from ICD-9-CM to ICD-10-CM
- Work closely with your coders to help make a smooth transition to ICD-10-CM documentation requirements.
- CMS Frequently Asked Questions

https://questions.cms.gov/faq.php?id=5005&faqId=12625
Summary

- Now is the time for your Diagnostic Radiology practice to implement clinical documentation improvements in areas that are targets for external compliance audits.

- In addition, it’s the time to ensure you are getting good strong clinical information from other areas of the hospital, such as the Emergency Room.

- ICD-10 will likely standardize terminology, provide access to detailed clinical outcomes, and facilitate health care transformation and reform.

- Discuss these with a near and long-term view and realign goals and objectives accordingly.
# Radiology Diagnosis Elements

<table>
<thead>
<tr>
<th>Radiology Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer</strong> - history of cancer versus active cancer, primary &amp; secondary sites</td>
</tr>
<tr>
<td><strong>Pain</strong> – acute/chronic, neoplasm-related, post-traumatic, post-thoracotomy, etc.</td>
</tr>
<tr>
<td><strong>Cerebral infarction and intracranial hemorrhage</strong> (vessel/event, current vs old, sequelae, traumatic vs nontraumatic hemorrhage)</td>
</tr>
<tr>
<td><strong>Atherosclerosis of the extremities and varicose veins</strong> (native vs graft, claudication/rest pain/ulcer/gangrene, location, inflammation/ulcer)</td>
</tr>
<tr>
<td><strong>Peptic ulcer</strong> – location &amp; complications</td>
</tr>
<tr>
<td><strong>Cholecystitis/cholelithiasis</strong> – location, obstruction, acute vs chronic</td>
</tr>
<tr>
<td><strong>Diverticulosis/diverticulitis</strong> – location, complications</td>
</tr>
<tr>
<td><strong>Arthritis</strong> – type, poly vs single joint, sequela of trauma, secondary to underlying disease</td>
</tr>
<tr>
<td><strong>Osteoporosis</strong>, pathological fracture, bone density tests</td>
</tr>
<tr>
<td><strong>Internal derangement of knee</strong> – old vs current injury, location, type</td>
</tr>
<tr>
<td><strong>Spondylosis and disc disease</strong> – spinal level, radiculopathy, myelopathy</td>
</tr>
<tr>
<td><strong>Pregnancy</strong> – trimester, weeks of gestation, incidental pregnancy</td>
</tr>
<tr>
<td><strong>Multiple gestation</strong> – chronicity/amnionicity, 7th character for fetus</td>
</tr>
<tr>
<td><strong>Diabetes and hypertension in pregnancy</strong>—gestational and pre-existing, diet vs insulin, PIH, pre-eclampsia</td>
</tr>
<tr>
<td><strong>Multiple injuries</strong> – designating the most severe injury</td>
</tr>
<tr>
<td><strong>Episode of care</strong> – initial vs subsequent, routine healing vs delayed/malunion/nonunion</td>
</tr>
<tr>
<td><strong>Fracture type</strong> – displaced, spiral, oblique, transverse, physeal, Gustilo, etc.</td>
</tr>
<tr>
<td><strong>Traumatic brain injury</strong>, LOC, and coma scale</td>
</tr>
<tr>
<td><strong>External cause of injury/illness</strong> – cause, place of occurrence, activity, status</td>
</tr>
</tbody>
</table>
## Top 20 Radiology ICD-9 to ICD-10 Codes

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Code</th>
<th>ICD-10 Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>162.9</td>
<td>C34.90</td>
<td>Malignant neoplasm of unspecified part of unspecified bronchus or lung</td>
</tr>
<tr>
<td>185</td>
<td>C61</td>
<td>Malignant neoplasm of prostate</td>
</tr>
<tr>
<td>786.2</td>
<td>R05</td>
<td>Cough</td>
</tr>
<tr>
<td>786.50</td>
<td>R07.9</td>
<td>Cough, unspecified</td>
</tr>
<tr>
<td>813.42</td>
<td>S52.599A</td>
<td>Unspecified fracture of the lower end of unspecified radius, initial encounter for closed fracture</td>
</tr>
<tr>
<td>845.00</td>
<td>S03.400A</td>
<td>Sprain of unspecified ligament of unspecified ankle, initial encounter</td>
</tr>
<tr>
<td>847.0</td>
<td>S06.919A</td>
<td>Sprain of unspecified muscle and tendon at ankle and foot level, unspecified foot, initial encounter</td>
</tr>
<tr>
<td>864.00</td>
<td>S13.400A</td>
<td>Sprain of ligaments of cervical spine, initial encounter</td>
</tr>
<tr>
<td>864.00</td>
<td>S13.800A</td>
<td>Sprain of joints and ligaments of other parts of neck, initial encounter</td>
</tr>
<tr>
<td>865.00</td>
<td>S36.000A</td>
<td>Injury, liver unspecified</td>
</tr>
<tr>
<td>720.5</td>
<td>M79.699</td>
<td>Pain in unspecified limb</td>
</tr>
<tr>
<td>714.0</td>
<td>M06.9</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>959.01</td>
<td>S09.800A</td>
<td>Other unspecified injuries of head, initial encounter</td>
</tr>
<tr>
<td>959.7</td>
<td>S09.900A</td>
<td>Unspecified injury of head, initial encounter</td>
</tr>
<tr>
<td>959.7</td>
<td>S58.800A</td>
<td>Other specified injuries of unspecified lower leg, initial encounter</td>
</tr>
<tr>
<td>959.7</td>
<td>S58.900A</td>
<td>Unspecified injury of unspecified lower leg, initial encounter</td>
</tr>
<tr>
<td>959.01</td>
<td>S58.810A</td>
<td>Other injuries of unspecified ankle, initial encounter</td>
</tr>
<tr>
<td>959.01</td>
<td>S58.910A</td>
<td>Unspecified injury of unspecified ankle, initial encounter</td>
</tr>
<tr>
<td>789.03</td>
<td>R10.31</td>
<td>RLQ abdominal pain</td>
</tr>
<tr>
<td>789.03</td>
<td>R10.32</td>
<td>LLQ abdominal pain</td>
</tr>
<tr>
<td>789.03</td>
<td>R10.39</td>
<td>Abdominal pain other specified site</td>
</tr>
<tr>
<td>810.10</td>
<td>R10.10</td>
<td>Upper abdominal pain, unspecified</td>
</tr>
<tr>
<td>810.2</td>
<td>R10.2</td>
<td>Pelvic and perineal pain</td>
</tr>
<tr>
<td>810.30</td>
<td>R10.30</td>
<td>Lower abdominal pain, unspecified</td>
</tr>
<tr>
<td>810.40</td>
<td>R10.40</td>
<td>Right upper quadrant pain</td>
</tr>
<tr>
<td>810.11</td>
<td>R10.60</td>
<td>Unspecified abdominal pain</td>
</tr>
<tr>
<td>810.11</td>
<td>R10.61</td>
<td>RUQ abdominal pain</td>
</tr>
</tbody>
</table>

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HIMSS is offering a helping hand

RESOURCES

American College of Radiology (ACR)
In order to assist its membership, the ACR has an ICD-10 Resources page on the ACR Website, and continues to post ICD-10 articles and updates in the ACR Radiology Coding Source, the ACR’s bi-monthly coding and reimbursement electronic newsletter.

Radiology Business Management Association (RBMA)
The Radiology Business Management Association (RBMA) offers an ICD-10 Tool Kit - a collection of resources that will help a radiology practice prepare to ensure a smooth transition. The toolkit provides a model plan that can be customized based on the group’s individual circumstances and resources. In addition to the toolkit, look to the RBMA to continue to offer ICD-10 coding education for radiology practices.
RESOURCES

Centers for Medicare and Medicaid (CMS)

HIMSS ICD-10 Playbook
http://www.himss.org/library/icd-10/playbook

ICD-10 Charts.com  http://www.icd10charts.com

AAPC  https://www.aapc.com/icd-10/codes/

Cypher Software http://icdlogic.com/

Radiology Business Management Association
http://www.rbma.org/ICD-10/
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