ICD-CM Coding
The Structural Considerations

Subscriber Webinar

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HOSPICE FUNDAMENTALS
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The Challenge

Hospices are being called upon to

1. Start using ICD-9 CM coding on its claims
2. Be prepared to transition to ICD-10-CM by 10/1/2014

Complicating the matter

1. We're late to the coding arena
2. We don't quite know what CMS is actually saying re which codes to include
3. We are struggling with decreasing revenues
4. We need time and energy to effectively advocate as CMS pushes for an apparent expansion of financial responsibility under the Hospice Medicare Benefit

Coding is a method of painting the picture – with a paint by number set.

Get Ready

Develop

- Broad understanding of the classification history
- Understanding of the resources
- Familiarity with some of the common terms and concepts

What Is the ICD?

- International Classification of Diseases - a medical classification system
- Desire and understanding of the need to classify deaths gained traction in the 17th century
- 1853 – agreement to establish worldwide uniform classification
- Modern day ICD grew from that; World Health Organization oversees
- Used worldwide for
  - Morbidity and mortality statistics
  - Reimbursement systems
  - Automated decision support
- Designed to allow comparisons & tracking

What is the ICD-CM?

ICD	used to code and classify mortality data from death certificates
ICD - CM	CM = clinical modification used to code and classify morbidity data from the inpatient and outpatient records and physician offices

Functions of the ICD-9 CM

Original Function: statistics and research

Current Functions Include:

1. Setting healthcare policy
2. Storing and retrieving data
3. Designing payment systems
4. Monitoring resource utilization
5. Tracking public health and risks
6. Designing healthcare delivery systems
7. Analyzing payments for health services
8. Implementing operational and strategic plans
9. Measuring quality, safety, and efficacy of care
10. Preventing and detecting healthcare fraud and abuse

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Limitations of the ICD-9 CM

- No more space to accommodate new codes
- Needed a system with the ability to
  - Measure quality of care
  - Initiate pay-for-performance
  - Evaluate resource utilization
  - Track public health threats, such as avian flu
  - Identify medical errors and patient safety issues
  - Exchange meaningful health data with other organizations and government agencies

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ICD-9-CM Components

Volume 1: Tabular list, structured numerically by body system
Volume 2: Alphabetical index of disease entries
Volume 3: Procedure codes (alphabetical and tabular lists)

Coding Conventions: included in Volumes 1 & 2

Official Coding Guidelines: set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM itself.

2014:
http://www.cdc.gov/nchs/data/icd/icd10cm_guidelines_2014.pdf

The Cooperating Parties

CMS	Maintains and updates the procedure portion (Volume 3)
CDC	Maintains and updates the diagnosis portion of the ICD-CM
AHA	Maintains the Central Office on ICD-CM to answer questions from coders; produces the Coding Clinic for ICD-CM, the official guidelines for ICD-CM usage
AHIMA	Provides training and certification for coding professionals

Official Sources for Coding Information

- Official Coding Guidelines
- Coding Conventions
- Coding Clinic
  - Approved publication by CMS
  - Published by the American Hospital Association
  - Provides clarification and guidance to further expand the Official Guidelines and Coding Manual
- Other CMS Guidance
  - Hospice Conditions of Participation
  - Medicare Benefit Integrity Manual
  - Medicare Reimbursement Manual
  - 2013/2014 Hospice Wage Index Final Rules

Resource: Coding Manual

- Many manual choices – all have the same basic information
- Differentiators
  - Print or on-line
  - Company specific aides and tools
- All companies now have a home care version

Resource: Official Guidelines

- A set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-9-CM manual.
- Provide additional instruction and are to be used as a companion to the official coding manual.
- Applicable to all health care settings, unless otherwise indicated.
- Adherence to these guidelines when assigning ICD-9-CM diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA).

- The Guidelines include:
  - Conventions for the ICD-CM
  - General Coding Guidelines
  - Chapter Specific Guidelines

- Accurate coding requires an understanding of the coding conventions and guidelines and how to use the code book.
  Judy Adams, Adams Homecare Consulting

No Matter What and Where…

The term *encounter* is used for __all__ settings, including hospital admissions.

The term *provider* is used throughout the guidelines to mean physician or other health care practitioner who is legally accountable for establishing the patient's diagnosis.

"A joint effort between the health care provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures."

Source: Introductory page of ICD-9-CM Official Guidelines for Coding and Reporting

Concepts with Which to Become Familiar

- Etiology / manifestation codes
- Mandatory multiple codes
- Late effect codes
- Sequencing
- "Code first the underlying condition"
- Coding the diagnosis rather than symptoms
- Acute and chronic conditions
- Pressure ulcer coding

Get Set

Where the rubber meets the road – and the toughest part

1. Determine primary hospice diagnosis
2. Identify other diagnoses
3. Determine which are related to the primary hospice diagnosis and which are not
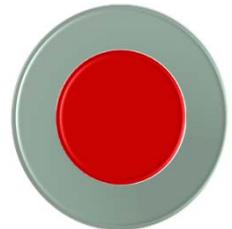
Federal Register — July 27, 2012

"…*We are clarifying that all of a patient's coexisting or additional diagnoses should be reported on the hospice claim*. We note that doing so will bring hospices into compliance with existing, longstanding policy, and will provide data needed for hospice payment reform. *Hospices should not report diagnoses which are unrelated to the terminal illness on their claims.* Hospice claims currently include a field for the patient's principal diagnosis, but allow for up to 17 additional diagnoses to be included on a paper UB–04 claim, or up to 24 additional diagnoses on the 837I 5010 electronic claim." 77 FR 44247

Federal Register — August 7, 2013

"We are clarifying that this principal diagnosis, along with the other related diagnoses, would be included on the hospice claim"

FY 2014 Wage Index Final Rule
78 FR 48247 August 2013

"…rather, [coding clarifications] are to ensure that all principal and diagnoses related to the terminal prognosis are captured on the Medicare hospice claims to more accurately describe hospice beneficiaries receiving the services, drugs, supplies, and DME hospices are required to cover under the regulations at § 418.200, § 418.202, and § 418.204.

FY 2014 Wage Index Final Rule
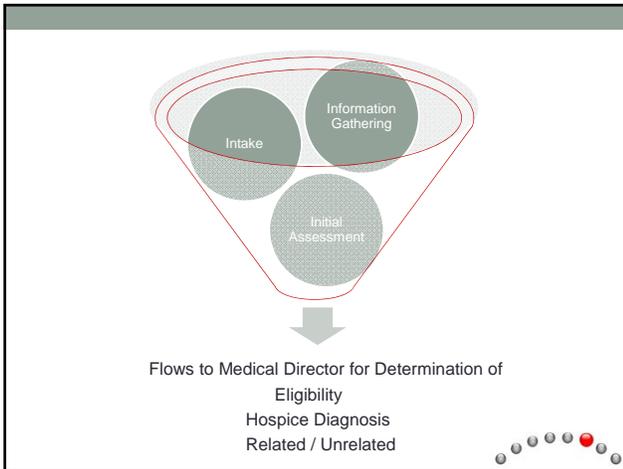78 FR 48247 August 2013

The Question

Are expectations of coverage expanding from coverage built around the "condition established after study to be chiefly responsible for the patient's admission" to anything related to the patient's prognosis?

Process Steps to Spell Out

- What needs to be done?
- When will it be done?
- What position is responsible for doing it?
- What process variations need to be anticipated and prepared for?

Flows to Medical Director for Determination of
Eligibility
Hospice Diagnosis
Related / Unrelated

Key Processes

- Determining diagnoses
- Determining coverage
- Documenting above
- Communicating DX & coverage decisions (internally and externally)
- Care planning for related and non-related DX
- Periodic review of determinations
- Managing changes in diagnoses

Plan for Variations, For Example

- Referral that meets six-month prognosis but diagnosis is not clear at time of admission
- In course of care, becomes clear that a different primary hospice diagnosis is more appropriate
- Short stay patients
- What other variations can you think of?

Go – It's Time to Code!

What do hospice regulations and ICD-CM coding have in common?

Both have an awfully
lot of grey!

Decisions to be Made

Two components to coding
1. Art: what disease process is bringing this patient to us?
2. Science: technical aspect of finding the right code

Who will do the coding?
- Dedicated coding position?
- Combined position?
- What training will the person have?
- Who will be your go-to resource?
- Would you outsource the technical component
- Are you expecting all your RN case managers to also be able to code?

Some Thoughts on Readiness

1. Before your attention is totally pulled to ICD-10-CM get your processes in place
2. Allocate adequate resources to
   - Complete necessary training
   - Support more complex processes
   - Secure additional physician time (possibly)
   - Accommodate more complete coverage
3. Be prepared with line of credit or adequate cash reserves in case claims processing is slowed in October 2014

How Will Coding Data Be Used?

- CMS is vigorously pushing to expand the scope of coverage for the Hospice Medicare Benefit – expect tie-in of hospice claim coding to claims from other Medicare providers
- Examples
  - Part D Claims
  - Hospital claims using 07 condition code as designation for stay unrelated to hospice terminal diagnosis
  - Possible comparison of providers related to use of additional codes included for specific diagnoses
  - What else?

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