ICD-10:
Last Minute Preparation
5 Months To Go

Prepared by: Rose T. Dunn, MBA, RHIA, CPA, FACHE
For: Greater St. Louis Healthcare Financial Management Association
Agenda

• Will it really happen
• What are the benefits
• What’s left to do
• Recent information
• ICD-11 and SNOMED CT
Will it happen?

- SGR had no mention of delay
- Could there still be a delay? Yes
  - Likely: ??
Benefits: The Case for ICD-10

• We’re not doing what others are doing:
• Data comparability with other countries:
• There no more room in ICD-9 for new codes:
• It will facilitate bio-surveillance activities:
• It will help control fraud and waste:
• It will facilitate distinguishing case mix complexity and severity:
• It will identify provider attempts to prevent health conditions and patient unwillingness:
• It will capture patient outcomes:
How will ICD-10 Help Providers (or Payers)

• The Case for ICD-10

  • **It will help control fraud and waste: Yes**
    • Diagnosis specific testing
    • Duplicative treatment of the same body part
    • Injuries: With or without liability (businesses, employers)
    • Healthcare acquired conditions

  • **It will facilitate distinguishing case mix complexity and severity: Yes**

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How Can ICD-10 Help Providers (or Payers)

- The Case for ICD-10
  - It will facilitate distinguishing case mix complexity and severity: Yes
    - Encounter codes include visits with and without abnormal results
    - Encounter codes distinguish when the visit is the first encounter or a follow up encounter for the same or different condition
    - If those secondary conditions MEAT (for physicians but also applies to hospitals), encounters will reflex the complexity and severity of cases treated
      - M-Condition is monitored
      - E-Condition is evaluated
      - A-Condition is assessed/addressed
      - T-Condition is treated
  - It will identify provider attempts to prevent health conditions and patient unwillingness: Yes
How Can ICD-10 Help Providers (or Payers)

• The Case for ICD-10

  • It will identify provider attempts to prevent health conditions and patient unwillingness: Yes
    • Codes for patients failing to take medications as prescribed
    • Codes for patients failing to have immunizations
    • Supports predictive modeling and identification for disease, care and utilization management
  
  • It will capture patient outcomes: Yes
How Can ICD-10 Help Providers (or Payers)

• The Case for ICD-10
  • It will capture patient outcomes: Yes
    • Good and bad
    • Focus for PI/LEAN
ICD-11 -- Happening Soon

• 2015: ICD-11 in beta
• 2017: ICD-11 “go-live”
• More info: http://www.who.int/classifications/icd/revision/en/
Why not skip to ICD-11?

- U.S. Adapts (clinically modifies) the ICD for use in the U.S.
- Takes time to get buy-in from the specialty groups
- System vendors have adapted applications for ICD-10
- ICD-11 differs from ICD-10
- Payers have adjusted payment algorithms for ICD-10
So, What’s Left To Do?

• Should be well on your way
• If you took a break:
  • You should have refreshed where you left off
  • Testing should be underway
  • Coder education completed
• If you kept going:
  • Took care of upgrades
  • Addressed documentation
  • Educated physicians
  • Routinely practiced coding
  • Conducted testing
Stay the Course

1. Complete your ICD-10 System Upgrades

2. Focus on your “ailments”
   • When the initial gap analysis was conducted
     • Were organization or workflow changes identified?
     • Did you identify some leakages?
     • Any risk areas uncovered?

3. Address physician documentation deficits
   • As valuable for ICD-9 as it will be for ICD-10, ICD-11...
Stay the Course

4. **Automate wherever possible**
   - Complete EHR Implementations/Expansions
   - Get rid of paper
   - Expand digital entry
   - Assess the value of Computer Assisted Coding
1. Continue/Complete the ICD-10 System Upgrades

- Many ICD-10 Upgrades included in MU2 upgrade(s)
  - Some ICD-10 upgrades now have upgrades!
- Continue internal testing
  - Integrated Testing (between your internal systems)
- Will ICD-10 documentation improvement efforts help meet MU?
  - CQMs
  - PQRS
  - Centers of Excellence
Think About

- Feeder systems (internal and external) that have the code(s) and send to another system or Vice Versa
- Any standalone systems that you provide flat file data or ADT data
  - Common in OB, PI, and research settings
- Registry data extracts and re-programming for those extracts
  - Cancer, Trauma, etc.
- Bolt on applications (3rd party): e.g. ABN, e-prescribing, etc.
  - ICD-10 ready?
- Any biomedical or drug dispensing equipment that requires entry of a code
- Don’t forget your affiliates (SNFs, Home Health, Hospice, etc.)
**Vendor Product Development:** All respondents have at least started this step and nearly 90% were at least halfway complete. More than a third have completed development, and about 40 percent say they are at least three-quarters complete. These numbers are similar to the August 2014 survey, suggesting only modest progress has been achieved since then.

**Vendor Product Availability:** About 60% indicated their vendor products were available or they had started customer testing. This is a slight decrease from about two-thirds in the August 2014 survey. However, the number that responded ‘unknown’ decreased from about 12% to just a handful.

**Provider Impact Assessments:** Just over one-third of providers responded that they had completed their impact assessment. This is a decrease from the August 2014 survey, in which slightly more than one-half indicated they had completed their assessment. Just over one-quarter responded "unknown," the same as in the previous survey. Further analysis shows that more than 60% of hospitals/health systems have completed assessments, while fewer than 20% of physician practices have done this.

Source: Health Data Management 4-7-15
System Updates and Go-Live Considerations

• If update not received yet:
  • Nail down the delivery time
  • No response: Shop quickly

• Interface engine challenges
  • Creating the routing for ICD-10 on the effective date

• Who is turning on ICD-10 on 10/1?
  • Will system base use of ICD-10 on date of service? Or is a manual intervention required?
  • Think about “rules” for services occurring over the transition period 9/30-10/1
2. Focus on Ailments - Effective use of resources

- **Address organizational structure changes**
  - **Consolidate resources**
    - Coding pools (professional and facility)
      - Leverage labor
        - Touch once/code twice
    - Consider space and technology requirements
    - Reduce external auditor risk
      - Professional bill not matching facility bill
2. Focus on Ailments-Effective use of resources

- Address organizational structure changes
  - Get the physicians OUT of the coding business
    - Get them INTO the documentation business
    - Look at “real time” documentation improvement tools
      - Don’t believe the hype from the Speech Recognition vendors
    - Continue education
      - Documentation Tips
  - Analyze their top 10-20 diagnoses for ICD-10 deficits
  - Update superbills/encounter forms
  - Identify credible sources of documentation to pre-populate fields of reports for the physicians
Think About

• Eliminating handwritten notes
• Updating forms, templates, macros in EHR
• Physician practices using organization’s encoding system (enterprise wide)
• Recreating their favorites
• Refreshing the problem lists
• Recruiting coders for physician practices and hospital
• Cross-training the coding team
2. Focus on Ailments-Revenue Leakages

- Deal with leakages
  - Lost revenue opportunities
    - Is ED coding for all procedures – Think Consultants/Think Technical Component
    - Is modifier -59 being inappropriately used
    - CDM
      - Drugs
    - Denials: What are the causes today?
      - Pre-authorizations
      - Medical Necessity
      - Lack of supporting documentation
    - External auditors are not going away
2. Focus on Ailments-Compliance Flags

Reduce risks: Compliance flags

- What did you uncover during your workflow evaluations?
  - Code Jamming
  - Duplicate claims
  - Hard coded providers
  - Incorrect codes on superbills
  - Incomplete orders and department initiated modifications
  - Facility claims driven by one diagnosis source/professional claims driven by another diagnosis source
  - Billing from Nursing Documentation—No physician documentation present
  - Excessive copy and paste
  - Facility level gaming ..................
3. Address Physician documentation deficits

- As valuable for ICD-9 as it will be for ICD-10, ICD-11 ...
  - Use ICD-10 to set the "gold standard" for documentation
  - Already trained your coders?
    - Have them continue to practice their ICD-10 coding....why?
      - Shorten the learning curve
      - Confirm true staffing needs
  - Add to the dual coding activities the responsibility of identifying documentation deficits
  - Pass findings to the CDIs or CMO/VPMA to address with the physicians
3. Address Physician documentation deficits

- Don’t limit your attention to inpatient
  - Medicare Advantage
  - ACA → HCC-type reimbursement structure
  - Outpatient encounters

- Are any denial categories due to documentation?
  - Invalid Diagnosis or Procedure Codes
  - Insufficient Information to Justify Services
  - Medical necessity
3. Address Physician documentation deficits

- Create and maintain your Dashboards:
  - CMI
    - By MD
  - Denials
    - By MD
  - Target your education!
4. Automate where possible

- **Complete EHR Implementations/Expansions**
  - Focus on MU2 (and MU3)
    - Get the bucks while you can
  - Reassess screens and fields that need to be mandatory for ICD-10
    - Route of chemotherapy administration
    - Weeks of gestation
  - Design templates for common reports and include what is necessary for ICD-10:
    - H&Ps, Consults, Discharge Summaries
    - Immediate post op progress note
    - Wound care
    - Bedside and other procedures
4. Automate where possible

- Fix the drop downs and pick lists
  - Indications for tests
  - Move **un**specified to the bottom
  - Use 3\textsuperscript{rd} party plug ins to help get to the specificity >
    - IMO (Intelligent Medical Objects)
- Throw away all quills!
  - Need digital documentation
4. Automate where possible

- **Get rid of paper**
  - Facilitates coder recruitment/retention
    - Allows use of coders located anywhere
    - Allows your staff to work from home
  - Reduces space and related services needs
    - Cafeteria, Parking, etc.
    - Allows the space to be used for patient services
  - Move off-site (cheaper real estate)
  - Evaluate your scanning operation – is it functioning optimally?
    - If not...fine tune it or replace it!
    - What is still quill-based? Automate it!
4. Automate where possible

- Expand digital entry
  - Get rid of copy and paste (OIG focus)
  - Negatively impacts coder productivity
    - Facilitates erroneous data
    - Does not contribute to content of the patient record
    - Does not demonstrate that the clinician really examined the patient
  - Electronic documentation facilitates use of Computer Assisted Coding

- Assess the value of Computer Assisted Coding
  - Mixed reviews
  - Why?
    - Cost
    - Poor installation
    - Didn’t perform as “sold”
    - Coder resistance

- Assess the value of Computer Assisted Coding
  - Don’t believe all the hype
    - If something razzle dazzles you...test it yourself
    - Don’t buy what you don’t need
    - Ask for proof
    - Contractually, tie vendor fees to successes they tout
4. Automate where possible-C.A.C. Computer Assisted Coding

- **What is it not doing well?**
  - Too many clicks:
    - Revisit workflow or address enhancements required with vendor
    - Missing details or adding too many codes
    - Incorrect parsing
  - Leverage your labor
    - Can we cut it “loose” to autocode?
  - User resistance?
4. Automate where possible: Computer Assisted Coding
User resistance -> Change

• Not just coders:
  • Compliance
  • Physicians
  • IT System Managers

• Approach:
  • Communicate
  • Involve
  • Seek input
  • Practice
  • Listen
  • Applaud
  • Confirm

- Don’t take short-cuts in the installation
  - Build HL-7 Interfaces...not PDF Interfaces
  - Flowchart work flows and then **validate them** – multiple times
  - 2-4 Monitors
    - CAC Application
    - Scanned document
    - Other Application
      - Encoder
      - Charge Entry
      - CDI
      - Reference sites
  - If you modify screens, templates, macros: You may need to re-parse and tune your C.A.C.

- Use Computer Assisted Coding for more than Coding
  - Case Finding:
    - CDI
    - CORE Measures
    - Safety/Quality Measures
    - PQRS elements
    - Other?
  - Should you install now?
    - Tuning
    - Identify potential ICD-10 codes
    - Slowdown

Leverage the cost of the product!
Develop Your Dashboard

- **Suggested Dashboard Elements:**
  - Records coded per hour
  - CMI
  - Requests for records
  - Days in A/R
  - Days in DNFC
  - Days in DNFB
  - Claim rejections
  - Denials by Payer
  - Medical necessity denials
  - Denials for “unspecified” dx
  - Cash on hand
Develop Your Dashboard

• There will be changes to Revenue Cycle after 10/1
• Need before and after data to discuss with your internal committees and the Board
  • Brief your board at every meeting about ICD-10
• Try to collect data from 10/1/14 so that you can compare to 10/1/15 and after
• Monitor more often than monthly after 10/1/15
What Else Should We Be Doing?
A. Collect and Use the data

• **Dual coding:**
  • Do it to hone the coding skills of your staff
  • Use the data to:
    • Forecast queries due to lack of specificity required
    • Predict time for effort
      • Labor projections/needs
    • Adjust Employed and Contracted Labor Budget
    • Focus educational efforts for CDIS and Coders
    • Target documentation voids
      • Which physicians need to be educated

• **Record review:**
  • Focus on the key attributes
# Common Attributes

<table>
<thead>
<tr>
<th>Documentation to Include</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chronicity</strong></td>
<td>Acute, Chronic, or both</td>
</tr>
<tr>
<td><strong>Specific Site</strong></td>
<td>Forearm, epigastric, transverse colon, subtrochanteric, upper quadrant</td>
</tr>
<tr>
<td><strong>Laterality</strong></td>
<td>Right, Left, Bilateral</td>
</tr>
<tr>
<td><strong>Specific Type of Condition</strong></td>
<td>Iron Deficiency Anemia; Systolic Congestive Heart Failure; Type 2 Diabetes Mellitus</td>
</tr>
<tr>
<td><strong>Etiology of the Diagnosis</strong></td>
<td>Chest pain due to gastroesophageal reflux disease; Left arm weakness due to previous stroke</td>
</tr>
<tr>
<td><strong>Link between Manifestation and the Underlying Disease</strong></td>
<td>Vascular insufficiency secondary to diabetic peripheral vascular disease; Ischemic cardiomyopathy secondary to hypertensive heart disease</td>
</tr>
<tr>
<td><strong>Complications of care</strong></td>
<td>Intraoperative, postoperative, mechanical malfunctions, infections</td>
</tr>
<tr>
<td><strong>Degree</strong></td>
<td>Mild, Moderate, or Severe; Extent, e.g. LOC</td>
</tr>
<tr>
<td><strong>Stage</strong></td>
<td>Stage I, II, and so forth, such as Stage IV decubitus ulcer</td>
</tr>
<tr>
<td><strong>Injury Details</strong></td>
<td>Place of occurrence and activity that caused the injury</td>
</tr>
<tr>
<td><strong>Episode of Care</strong></td>
<td>Last week, healed, yesterday, initial, subsequent</td>
</tr>
<tr>
<td><strong>Trimester</strong></td>
<td>Document daily-conditions must be associated with 1\textsuperscript{st}, 2\textsuperscript{nd}, 3\textsuperscript{rd} trimester</td>
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Courtesy of First Class Solutions, Inc.
A. Collect and Use the data

- **Capture dual coding data**
  - What happens with your DRGs?

Results: 1,000+ discharges

DRG Shift Rate: 5%

Coding Time:

- Our Staff’s Current: 3-4 inpatients/hour (15-20 min)
- Medical Cases: ~30 minutes; 1 yr ago: ~42 minutes
- Surgical Cases: ~45 minutes; 1 yr ago: ~53 minutes
- PRACTICE HELPS!
A. Collect and Use the Data

• **Two studies:**
  • 10/13 to 10/14: ICD-10 coding time dropped from 53.4 minutes to 43.3 minutes per inpatient encounter (2 coders)
  • Montefiore Study (2013): 7 month study. Coded 22,848 records. Queried 3,387 of which 384 were answered by physicians.
    • ICD-9: Coded 18.75/day 24 minutes each
    • ICD-10: Coded 10/day 46.2 minutes each
A. Collect and Use the Data

• Practice Helps
  • Native coding – from the book
  • Encoders are not yet completely perfected
  • Staff must understand the coding rules
    • To know if they are taking the wrong path
  • When to practice:
    • Now (A little each day)
    • Later (Later-concentrated)
    • Both
A. Collect and Use the Data

• Practice and Perfection:
  • Dual coding:
    • Tests both CDIS’ and Coders’ skills on current records
      • Backfill
    • Test your applications
      • Will they hold both codes?
        • Workers Compensation and No Fault
        • Grantors
        • Trading partners not ready
    • Different results between native and encoder: Which one is correct?
A. Collect and Use the data

- Base your managed care contracts evaluations on your data
  - If paid on DRG: Remember some CC/MCCs are no longer included in some of the ICD-10 DRGs
  - Watch for letters from your payers
    - Appeal rights
    - Statistically valid sample
  - Where we’ve seen “shifts”
# Rose’s Shift List

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<th>ICD-9</th>
<th>ICD-10</th>
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Recent Information on Impact

- Advisory Board (1/26/15): Dual Coding 8,000 cases
  - No change: 95.7%; Change: 4.3%
  - Negative impact: 1.9% (Average loss: $4,036)
  - Positive impact: 2.4% (Average gain: $6,113)
- 11.6% changed from medical ↔ surgical
  - Medical to Surgical: $9,978
  - Surgical to Medical: -$18,404
B. Continue Payer Testing

• What have you discovered from your payer testing?
  • Did the scenarios change when you received your results back?
  • Did the payer make some assumptions that were not documented in the scenario?
  • Did the choice between 2 principles always get downgraded to the lower paying DRG?
B. Continue Payer Testing

- It tests the upgrades
- Allows you to test more scenarios – not just the cherry-picked ones
- Is your clearinghouse testing?

Last Medicare End-to-End Opportunity:
- July 20 through 24, 2015
- NOW CLOSED TO NEW REGISTRANTS
B. Continue Payer Testing

- **End-to-End vs. Acknowledgement**
  - **Acknowledgement**: Received it
  - **End-to-End**: How the process will work in “real life”—all steps
    - Involve your charge entry, coders/providers, coding edit system, claim edit system, clearinghouse, payer processing, payer adjudication, payer remittance
B. Continue Payer Testing

- The test sample
  - Top 25 DRGs
  - Top 100 ICD-9 codes converted to ICD-10
  - Codes with errors (0 vs O)
  - All diagnosis and procedure fields filled
    - Cause of injury – NEWS from some payers: **Must be complete for all attributes**
      - What happened - Fell from bike
      - Where - In the street
      - What were you doing at the time - Participating in a bike race
      - What was the person status (occupation) - Professional cyclist
  - Unusual services unique to your organization
  - Print a claim
B. Continue Payer Testing

• **Use results for:**
  - Budget forecasting
  - Fine-tuning your payer contracts
  - Cleaning up current dirty claim issues

• **Unsuccessful being selected for Testing?**
  - Some payers have posted results on health systems
  - Consider organizing a “system”
    - CAH, RHC, Behavioral Health Collaboratives
  - Check if your clearinghouse is testing
  - Request a provider relations meeting to review a small file of your claims to determine reimbursement
• **Internal Impact Assessment:** About 80% of health plans had completed their impact assessment, up from about three-quarters in the August 2014 survey and 12% were nearly complete. Only four respondents were less than halfway complete. This shows continued progress, although all should have been complete by this point.

• **Health Plan Testing:** Over one-half of health plans have begun external testing, and of these, a few have completed testing. This is a slight improvement from the previous survey. About 40% expected to begin external testing in the first or second quarter of 2015, but a few expect to start in the third quarter. In the August 2014 survey, slightly more than one quarter did not expect to begin external testing until 2015. This reflects a shift toward a later start for external testing for some organizations.

Source: Health Data Management 4/7/15
WEDI Report 3/2015

• **Provider Testing:** Just one-quarter of provider respondents had begun external testing, and only a few others had completed this step. This is actually a decrease from the one-third of provider respondents that had begun external testing in the August 2014 survey. More than one-quarter responded that they do not expect to begin external testing until the second or third quarter of 2015 and, disconcertedly, more than one-third responded "unknown." Further analysis shows that just more than one-half of hospitals/health systems had started external testing, and a few report say they have completed testing. Only about 10% of physician practices had started external testing.

Source: Health Data Management 4/7/15
**External Testing Approach:** Fewer than one quarter of health plan respondents indicated they planned to test with the majority of providers, while 60% indicated they would test with a sample of providers. Ten percent indicated they planned to test only with clearinghouses. This is similar to the responses in the August 2014 survey. About one-third of provider respondents indicated they had tested or planned to test with multiple payers, up slightly from the number in the August 2014 survey. About 30% responded that they would test only with clearinghouses, which is an increase from 20% in the previous survey.

Source: Health Data Management 4/7/15
Important Milestones – Testing (As of 10/14)

- **United Healthcare:**
  - Completed End-to-End Transaction Pilots: 4,000 claims, 4.2% of the claims generated a valid **DRG shift-2.3% to higher paying DRG, 1.9% to lower paying DRG**;
  - ~2% of the Professional and Laboratory Claims generated different payment results

- **Aetna:** 5 cycles of claim reviews:
  - 16.6% of claims resulted in DRG change with an **overall 1.7% increase in DRG weight change**
    - 16% of the changes due to code specificity
  - 1.3% of Outpatient claims had payment variations
  - 2.3% of the Professional claims had payment variations
  - Coder productivity negatively impacted
Important Milestones-Testing

• Anthem/Blue Cross: 4/2015 Report

We successfully tested with the five (5) local claims platforms that support our 14 Blue Markets and the two (2) national platforms, FEP and NASCO. We were able to process over 6,900 test claims submitted by providers. Claim edits performed as expected in our test environment. Types of claims included:
  • Inpatient – 65%
  • Outpatient – 11%
  • Professional – 23%

For inpatient claims, approximately 15% of the claims tested demonstrated some DRG shifts in certain categories, consistent with industry findings. Industry analysis of these DRG shifts has resulted in corrections in the subsequent DRG grouper versions so that the shifts are no longer happening.

For the outpatient and professional claims tested, we found no significant shifts in the ICD-10 coded claims. There was also no shift in benefit categories (i.e., preventive, emergency, etc.)

Source: http://www.anthem.com/ca/provider/f0/s0/t0/pw_e232787.pdf?refer=provider
Anthem: 4/2015 Report

- 2014: Successfully exchanged claim files with ICD-10 codes with these clearinghouses.
  - AthenaHealth
  - ClaimLogic
  - Emdeon
  - Gateway EDI
  - GE Health
  - MedAssets
  - Navicure
  - NEBO/Passport
  - Quadax
  - RealMed/Availity
  - RelayHealth
  - SSI
  - Zirmed

Who Tested With Us

Test participants included the following in our 14 Blue Markets (CA, CO, CT, GA, IN, KY, ME, MO, NV, NH, NY, OH, VA, WI):
- 44 provider organizations (63 entities)
- 36 Hospitals
- 25 Professional Provider Groups
- 13 Clearinghouses

Future Testing with Providers

This information was from the 2014 End to End Testing with providers and clearinghouses. Though we consider this testing successful, we will continue to verify our findings with additional internal analysis and a limited external testing effort in 2015. Participants for testing have already been identified for this year’s testing. No additional providers are needed.

Source: http://www.anthem.com/ca/provider/f0/s0/t0/pw_e232787.pdf?refer=provider
C. Don’t Stop Now!

- Continue coder recruitment, retention, and growing coder initiatives
- Expand CDI to all case-based payers
  
  ✔ Don’t forget to hire additional CDIs for ICD-10 Go-Live; It will take them longer to do their jobs as well.

- Continue documentation improvement efforts and education
- Get rid of reports that are not being used
- Facilitate documentation capture from all credible sources and pre-populate physician documents to save physician the documentation efforts
Recruitment and Staffing

• Make sure you have at least 2 contract coding contracts in place
• Consider retention bonuses for your existing staff
  • Very valuable commodities
• Consider recruitment bonuses…but recognize that there will be a ripple effect in the community
• Coding staff desire more than money:
  • Workspace
  • Flexibility
  • Pajamas
  • Equipment
  • Resources
  • Recognition
C. Don’t Stop Now!

- Shorten Medical Staff Rule for record completion (DNFB)
- Focus on problem lists: Do they reflect the most current conditions and all ACTIVE conditions
- Implement DSM5: At the same time as ICD-10
- Don’t ignore E&M coding (External Auditor focus)
- Minimize or eliminate the causes for all denials
- Implement ABNs!
  - Requires scripts and training of front-end/access staff
Issues associated with Implementing ICD-10

• The code structure
  • Alpha-numeric
  • 0 and O
  • 1 and I

1 2 3 4 5 6 7

Category

Etiology, Anatomic Site, Severity

Extension
ICD-10 CM Code Structure

- **ICD-9** codes are made up of 3-5 alpha-numeric digits.
- **ICD-10** codes are made up of 3-7 alpha-numeric characters. Some codes are required to be 7 characters long.
- Alphas and numeric: More time
- Example:
  - Unspecified right ulna fracture in **ICD-9**: 813.82.
  - Unspecified right ulna fracture shaft, closed, right, initial encounter, in **ICD-10**: S52.201A.
  - O88.012: Air embolism in pregnancy, first trimester
  - I97.611: Post-procedural hemorrhage and hematoma of a circulatory system organ following cardiac bypass
ICD-10 CM Code Structure

• More codes – More time
  • I97.611: Post-procedural hemorrhage and hematoma of a circulatory system organ following cardiac bypass
    • ICD-9: 998.11 Hemorrhage complicating a procedure (no indication intra-/post-)
    • ICD-9: 998.12 Hematoma complicating a procedure (no indication which system)
  • Intra- and post-procedural complication codes for every organ system for ICD-10
    • N99.61: Intraoperative hemorrhage and hematoma of a genito-urinary system organ
    • Physician documentation will need to specify whether intra- or post-operative or both and coder will need to determine system impacted
ICD-10 PCS

• Created by the U.S. for the U.S.
  • No benchmarks (This means we have no idea what it will do to productivity or reimbursement!)
• More detailed than any other country’s:
  • 72,000 procedures in U.S.’s PCS
  • Canada has 17,000 procedures in its CCI
• Terminology has changed
• Approximately 80 root operations
• Some root operations will be based on the method or approach
• Only for use in hospitals.....as of now
ICD-10 PCS vs. CPT-4®

1. Medical-Surgical
2. Obstetrics
3. Placement-Anatomical Regions and Orifices
4. Administration
5. Measurement and Monitoring
6. Extracorporeal Assistance and Performance
7. Extracorporeal Therapies
8. Osteopathic
9. Chiropractic
10. Imaging
11. Nuclear Medicine
12. Radiation Oncology
13. Physical Rehabilitation and Diagnostic Audiology
14. Mental Health
15. Substance Abuse

CPT-4 is a registered trademark of the American Medical Association
ICD-10-PCS Code Structure

- In **ICD-9**, all procedure codes are 4 numbers long.
- In **ICD-10-PCS**: **required** to contain 7 characters--alpha-numeric.
- ICD-10 does not allow for the use of eponyms.
  - Terms such as Ogilvies, Hartmann procedure, Billroth procedures are not identified and **coders will no longer be able to locate codes based on that terminology**.
    - Why?
  - Surgeons: must describe the procedure!

### Section Body System Root Operation Body System/Region Approach Substance Qualifier

Use your intraoperative OR Team to help!
Why?

No eponyms or common procedure names

The terminology used in ICD-10-PCS is standardized to provide precise and stable definitions of all procedures performed. This standardized terminology is used in all ICD-10-PCS code descriptions.

As a result, ICD-10-PCS code descriptions do not include eponyms or common procedure names. Two examples from ICD-9-CM are 22.61, "Excision of lesion of maxillary sinus with Caldwell-Luc approach," and 51.10, "Endoscopic retrograde cholangiopancreatography [ERCP]." In ICD-10-PCS, physicians’ names are not included in a code description, nor are procedures identified by common terms or acronyms such as appendectomy or CABG. Instead, such procedures are coded to the root operation that accurately identifies the objective of the procedure.

The procedures described in the preceding paragraph by ICD-9-CM codes are coded in ICD-10-PCS according to the root operation that matches the objective of the procedure. Here the ICD-10-PCS equivalents would be Excision and Inspection respectively. By relying on the universal objectives defined in root operations rather than eponyms or specific procedure titles that change or become obsolete, ICD-10-PCS preserves the capacity to define past, present, and future procedures accurately using stable terminology in the form of characters and values.
Procedure Coding System
Operative Approaches

1. Open
2. Percutaneous
3. Percutaneous endoscopic
4. Via Natural or Artificial opening
5. Via Natural or Artificial opening endoscopic
6. Via Natural or Artificial opening with percutaneous endoscopic assistance
7. External
Procedure Coding System

• Coder will translate surgeon’s operative report to the new root operation
  • **Assumption**: The physician’s documentation will allow the coder to translate accurately

• **Example**: The documentation indicates that the patient is on the ventilator and the coder knows that the correct ICD-10 procedure definition is “Performance” and will apply the code accordingly.
ICD-10 Example: Laparoscopic Appendectomy

- **ICD-9:** 47.01
- **ICD-10 PCS:**
  - 0 – Medical and Surgical (section of the coding classification)
  - D – Gastrointestinal System (body system)
  - T – Resection (root operation)
  - J – (body part)
  - 4 – (approach)
  - Z – (device)
  - Z – (qualifier)
# ICD-10 Example: Laparoscopic Appendectomy

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Medical and Surgical</td>
<td>Resection: Cutting out or off, without replacement, all of a body part</td>
</tr>
<tr>
<td>D</td>
<td>Gastrointestinal System</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Esophagus, Upper</td>
<td></td>
<td>Z No Device</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>2 Esophagus, Middle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Esophagus, Lower</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Esophagogastric Junction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Esophagus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Stomach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Stomach, Pylorus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Small Intestine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Duodenum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Jejunum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Ileum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Ileocecal Valve</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Large Intestine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F Large Intestine, Right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G Large Intestine, Left</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H Cecum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J Appendix</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KAscending Colon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L Transverse Colon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M Descending Colon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N Sigmoid Colon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P Rectum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q Anus</td>
<td>Open</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percutaneous Endoscopic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Via Natural or Artificial Opening</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Via Natural or Artificial Opening Endoscopic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Procedure Coding System
Devices and Qualifiers

• **Devices**
  • Grafts and Prostheses: Example: Joint prostheses
  • Implants: Example: Breast implant
  • Simple or Mechanical Appliances: Example: External Fixator
  • Electronic Appliances: Example: Pacemaker

• **Qualifiers:** Further describe the device or provide other specificity to the root operation
Example: A non-autologous platelet transfusion via a central venous line

- Character 1 (Section): 3 Administration
- Character 2 (Body System): 0 Circulatory
- Character 3 (Root Operation): 2 Transfusion
- Character 4 (Body System/Region): 4 Central Vein
- Character 5 (Approach): 3 Percutaneous
- Character 6 (Substance): R Platelets
- Character 7 (Qualifier): 1 Non-autologous

ICD-10-PCS code: 30243R1

Source: https://aafp.codeitrightonline.com/ciri/coding-administration-procedures-in-icd-10-pcs.html
The Query Factor

- Montefiore Project
- 22,848 records
  - ICD-10 Query Rate: 14.8% (3,387)
    - Answered: 11.3%
    - Unanswered: 88.7%
  - ICD-9 Query Rate: 4.4%
    - Answered: 56%
    - Unanswered: 44%

Impact on reimbursement
ICD-10 PCS – Example: Biopsy, external ear (69100)

<table>
<thead>
<tr>
<th>Section</th>
<th>0 Medical and Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body System</td>
<td>9 Ear, Nose, Sinus</td>
</tr>
<tr>
<td>Operation</td>
<td>B Excision: Cutting out or off, without replacement, a portion of a body part</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 External Ear, Right</td>
<td>Open</td>
<td>Z No Device</td>
<td>X Diagnostic Z No Qualifier</td>
</tr>
<tr>
<td>1 External Ear, Left</td>
<td>Percutaneous</td>
<td>Z No Device</td>
<td>X Diagnostic Z No Qualifier</td>
</tr>
<tr>
<td>K Nose</td>
<td>Percutaneous Endoscopic</td>
<td>Z No Device</td>
<td>X Diagnostic Z No Qualifier</td>
</tr>
<tr>
<td>3 External Auditory Canal, Right</td>
<td>Open</td>
<td>Z No Device</td>
<td>X Diagnostic Z No Qualifier</td>
</tr>
<tr>
<td>4 External Auditory Canal, Left</td>
<td>Percutaneous Endoscopic</td>
<td>Z No Device</td>
<td>X Diagnostic Z No Qualifier</td>
</tr>
<tr>
<td>5 Middle Ear, Right</td>
<td>Via Natural or Artificial Opening</td>
<td>Z No Device</td>
<td>X Diagnostic Z No Qualifier</td>
</tr>
<tr>
<td>6 Middle Ear, Left</td>
<td>Via Natural or Artificial Opening Endoscopic</td>
<td>Z No Device</td>
<td>X Diagnostic Z No Qualifier</td>
</tr>
<tr>
<td>9 Auditory Ossicle, Right</td>
<td>Open</td>
<td>Z No Device</td>
<td>X Diagnostic Z No Qualifier</td>
</tr>
<tr>
<td>A Auditory Ossicle, Left</td>
<td>Z No Device</td>
<td>X Diagnostic Z No Qualifier</td>
<td></td>
</tr>
<tr>
<td>D Inner Ear, Right</td>
<td>Z No Device</td>
<td>X Diagnostic Z No Qualifier</td>
<td></td>
</tr>
<tr>
<td>E Inner Ear, Left</td>
<td>Z No Device</td>
<td>X Diagnostic Z No Qualifier</td>
<td></td>
</tr>
</tbody>
</table>
C-Section: Excerpts from Actual Operative Reports

- TITLE OF SURGERY: REPEAT LOWER-SEGMENT TRANSVERSE CESAREAN SECTION.

- OPERATION PERFORMED: Primary cesarean section.
C-Section

Coder will need to read operative report and if documentation is not there...Query
D. Collaborating with your Trading Partners

• Getting Up to Speed
  • State health commissions or health data collection entities (i.e. HIDI)
  • Quality and Patient Satisfaction reporting entities
  • Core Measures
  • Billing companies for providers
  • Companies that utilize ordering software bolted on to your system (e-prescribing, surgical supplies, etc.)
  • Cancer, trauma, and other registries
  • Grantors

(c) 2015 First Class Solutions, Inc.
D. Collaborating with your Trading Partners

• **What needs to be done:**
  • Defining extracts in ICD-10
  • Sending ICD-10 tagged data and Receiving it
  • Returning ICD-10 tagged data
  • Any ordering system with external vendors (i.e. DME, surgical supply, or pharmaceutical companies)
  • HIDI is offering monthly data submissions  
    • Think about how useful it may be to have your ICD-10 data on a monthly basis especially for comparative purposes!
Other System Related Issues

- Modify custom reports (or wait)
- Consider technology that will prompt physicians for missing ICD-10 elements
Other Considerations

• Keyboard training
• Ensuring contracts in place for coding and CDI support
• Ensuring staff in place in patient accounts for claim rejections and edits
• Additional support for record copies
• Recurring accounts and precerts-surgery & ancillary procedures:
  • When (as of what date) will each of the major commercial payers accept a pre-authorization request with an ICD-10 code for services that will occur on or after 10/1/15?
  • Will each of the commercial payers require a provider to RE-pre-authorize a service with an ICD-10 code that has been authorized already with an ICD-9 code and extends over the 10/1/15 date?
Recognize

• Coding productivity will never return to “today”
• DNFC will increase...and never return to “today”
• DNFB will increase...and never return to “today”
• A/R will likely increase
• You should be capturing metrics today to be able to compare next year
• Educate and keep your board informed
• Audits will increase post 10/1/15
What If?
What if?

What if?

✓ We don’t go to ICD-10 in 2015?

☐ What’s the harm?

What if?

✓ An Executive Order was written tomorrow to implement ICD-10 for Hospitals only? Or implement PCS only?

☐ Will our Hospital systems accommodate this?

☐ Will the payers’ systems be able to accommodate A claims on ICD-10 and B claims on ICD-9?
What If?

✓ EHRs: Everyone 2016 (well, maybe)
✓ All EHRs required to have SNOMED-CT
✓ Many information systems have LOINC for laboratory and other clinical testing results (Logical Observation Identifiers, Names, and Codes)
What if?

- SNOMED-CT
  - Systematized Nomenclature of Medicine (Clinical Terms)
  - Created originally by the College of American Pathologists
    - In 2007, transferred to International Health Terminology Standards Development Organization IHTSDO
What if?

- **SNOMED-CT**
  - Highly sophisticated vocabulary with artificial intelligence to link terminology and decipher attributes, link test results, causal agents, and “codify” conditions, treatment and procedures—**reads digital documentation ONLY**
IHTSDO collaborates internationally with leading e-health countries:

- Australia,
- Canada,
- Czech Republic,
- Denmark,
- Estonia,
- Hong Kong,
- Iceland,
- Israel,
- Lithuania,
- Malaysia,
- Malta,
- Netherlands,
- New Zealand,
- Poland,
- Singapore,
- Slovak Republic,
- Slovenia,
- Spain,
- Sweden,
- United Kingdom,
- United States and
- Uruguay
SNOMED-CT

- SNOMED CT is a multinational and multilingual terminology (including different languages and dialects)

- Available in:
  - American English,
  - British English,
  - Spanish,
  - Danish and
  - Swedish, with other translations under way or nearly completed in French and Dutch.
SNOMED-CT and ICD-11

SNOMED CT:
- Cross maps to: ICD-9-CM, ICD-10, ICD-O-3, ICD-10-AM, Laboratory LOINC and OPCS-4 (used by National Health Services and is comparable to CPT-4).
- Is currently used in a joint project with the WHO as the ontological basis of the upcoming ICD-11.
  - 2017
SNOMED’s logic

- **[Condition]** “Third degree burn of left index finger caused by hot water"

284196006 | burn of skin | :
116676008 | associated morphology | = 80247002 | third degree burn injury |
272741003 | laterality | = 7771000 | left |
246075003 | causative agent | = 47448006 | hot water |
363698007 | finding site | = 83738005 | index finger structure

**Procedure** represents activities performed in the provision of health care. This includes not only invasive procedures but also administration of medicines, imaging, education, therapies and administrative procedures (e.g. appendectomy, physiotherapy, subcutaneous injection).
SNOMED and Procedures

**Attributes used to define procedure concepts:**

- **Procedure site** describes the body site acted on or affected by a procedure.
- **Procedure morphology** specifies the morphology or abnormal structure involved in a procedure.
- **Method** represents the action being performed to accomplish the procedure. It does not include the surgical approach, equipment or physical forces.
- **Procedure device** describes the devices associated with a procedure.
- **Access** describes the route used to access the site of the procedure.
- **Direct substance** describes the substance or pharmaceutical / biologic product on which the procedure’s method directly acts.
- **Priority** refers to the priority assigned to a procedure.
- **Has focus** specifies the clinical finding or procedure which is the focus of a procedure.
- **Has intent** specifies the intent of a procedure.
- **Recipient category** specifies the type of individual or group upon which the action of the procedure is performed.
- **Revision status** specifies whether a procedure is primary or a revision.
- **Route of administration** represents the route by which a procedure introduces a given substance into the body.
- **Surgical approach** specifies the directional, relational or spatial access to the site of a surgical procedure.
- **Using substance** describes the substance used to execute the action of a procedure, but it is not the substance on which the procedure’s method directly acts.
- **Using energy** describes the energy used to execute an action.
SNOMED and Procedures

- **Attributes used to define evaluation procedure concepts**
  - **Has specimen** | specifies the type of specimen on which a measurement or observation is performed.
  - **Component** | refers to what is being observed or measured by a procedure.
  - **Time aspect** | specifies temporal relationships for a measurement procedure.
  - **Property** | specifies the kind of property being measured.
  - **Scale type** | refers to the scale of the result of an observation of a diagnostic test.
  - **Measurement method** | specifies the method by which a procedure is performed.

- **Attributes used to define specimen concepts**
  - **Specimen procedure** | identifies the procedure by which a specimen is obtained.
  - **Specimen source topography** | specifies the body site from which a specimen is obtained.
  - **Specimen source morphology** | specifies the morphologic abnormality from which a specimen is obtained.
  - **Specimen substance** | specifies the type of substance of which a specimen is comprised.
  - **Specimen source identity** | specifies the type of individual, group or physical location from which a specimen is collected.
What do you think?

• Could SNOMED be tied to Revenue Codes?
• Could SNOMED be tied to DRGs?
• What should our coders be learning?
• Which classification system will facilitate health information exchange?
• Will CDI continue to be important with SNOMED?
• Should we skip to SNOMED?
• It’s all about physician documentation!
Thank you for your time today!
About the Speaker

Ms. Dunn is a Past AHIMA President and recipient of AHIMA’s 1997 Distinguished Member and 2008 Legacy Awards. She is Chief Operating Officer of St. Louis-based, First Class Solutions, Inc., a national health information management consulting firm providing coding compliance and HIM operational consulting services. Rose is active in ACHE, AICPA, HFMA, and AHIMA. Ms. Dunn is the author of Dunn & Haimann’s Healthcare Management published by Health Administration Press.

Rose T. Dunn, MBA, RHIA, CPA, FACHE, FHFMA
AHIMA Approved ICD-10CM/PCS Trainer
Rose.Dunn@FirstClassSolutions.com
800-274-1214
Disclaimer

- Some of the concepts and materials in this presentation have been presented elsewhere including, but not limited to:
  - ACHE’s Congress
  - AHIMA’s ICD-10 Summit
  - State HIMA and HFMA meetings
  - The Healthcare Roundtable
  - Missouri Hospital Association
  - Other professional association meetings
Resources

• Tools: WEDI.org (http://www.wedi.org/topics/icd-10/icd-10-implementation-success-initiative)

• RESOURCES:
  • ICD-10 Issue Reporting System
  • GUEST BLOG: Key Takeaways from the WEDI and HIMMS ICD-10 Summit
  • Diagnosis Code Set General Equivalence Mappings
  • Impact of the Transition to ICD-10 on Medicare Inpatient Hospital Payments
  • Provider Resources ICD-10 Implementation Guide
  • Checklists, Timelines and Project Guides with ICD-10 transition tasks and estimated timeframes
Resources

- Tools: WEDI.org (http://www.wedi.org/topics/icd-10/icd-10-implementation-success-initiative)
  - RESOURCES:
  - Implementation Planning - Get step-by-step information to help you plan for the transition.
  - Communicating about ICD-10
  - Medscape Modules - Medscape Education modules offer guidance for small practices making the transition to ICD-10. Continuing medical education (CME) and continuing education (CE) credits available to physicians and nurses
Resources

- **AHA**: http://www.aha.org/advocacy-issues/icd-10.shtml
  - ICD-10 Executive Guide
- **AHIMA**: http://www.ahima.org/topics/icd10/
  - Achieving ICD-10-CM/PCS Compliance in 2015: Staying the Course for Better Healthcare
  - ICD-10 Implementation Toolkit
  - ICD-10 Preparation Checklist
  - CMS Road To 10 Resources
  - MLN Connects: ICD-10 Coding Basics Video
  - Historical ICD Timeline
  - ICD-10 Playbook
  - Top Ten ICD-10-CM/PCS Questions
- **HIMSS**: http://www.himss.org/library/icd-10-transition
  - Whitepapers
  - ICD-10 National Pilot Project
Resources

- **MOHIMA:** [www.mohima.org](http://www.mohima.org)
  - On demand archived educational programs on ICD-10
- **ICD-10 Innovative Ideas**
  - HIMSS ICD-10 National Pilot Program
  - Study Stack Flash Cards
  - CSA ICD-10 Activities
  - Electronic Efficiency Energizes Educational Experience
  - Cutting Communication Chaos
  - 5 ‘Gotchas’ of ICD-10 Implementation
  - Roadmap for Implementation Outline
  - Stakeholder Roadmap
  - ICD-10 PCS Device Key 2012
  - My Gotcha Moment—Dicey Device-ology
  - EMR Template Innovative Idea
  - ICD10 and Your Documentation Gap Analysis and Link
Resources

- **CMS**: www.cms.gov/icd10
  - Video: ICD-10: Getting From Here to There -- Navigating the Road Ahead
  - Video: ICD-10 and Clinical Documentation
  - Expert Column: Preparing for ICD-10: Now Is the Time
  - CMS Implementation Planning
  - Provider Resources
  - Medicare Fee-For-Service Provider Resources
  - Medicaid Resources
  - Payer Resources
  - Vendor Resources
  - Statute and Regulations
  - 2015 ICD-10-CM and GEMs
  - 2015 ICD-10 PCS and GEMs