ICD-10 Changes Everything in the Revenue Cycle

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Education
Compliance
Commitment

ICD-10 Implementation

- WHO ?
- What ?
- When ?
- Why ?
- How ?

It’s on your doorstep! The biggest change to happen in Health Information Management and Revenue Cycle in more than 30 years.

Preparation is the KEY!

Will you be ready?

ICD-10

- WHO (World Health Organization) owns & publishes ICD (International Classification of Diseases).
- WHO endorsed ICD-10 in 1990; members began using ICD-10 or modifications in 1994.
- U.S. is only industrialized country not using ICD-10, for morbidity reporting (coding diseases, illnesses, injuries in a healthcare setting).
- The U.S. has used ICD-10 for mortality reporting (coding of death certificates by Vital Statistics offices) since 1999.

Coordination & Maintenance Committee

- ICD-9-CM Coordination and Maintenance Committee is made of 4 parties:
  - National Center for Health Statistics (NCHS) – responsible for diagnoses (Volumes 1 & 2)
  - Centers for Medicare and Medicaid Services (CMS) – responsible for procedures (Volume 3)
  - American Hospital Association (AHA)
  - American Health Information Management Association (AHIMA)

What is ICD-9-CM?

- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is based on the WHO ICD-9 standard diagnostic classification system.
- Volumes 1 & 2 (diagnosis codes) applies to ALL settings.
- Volume 3 (procedure codes) applies to inpatient hospital only.
- ICD-9-CM diagnosis codes are required under HIPAA for uniform claim submission.

Non-HIM Uses For ICD-9-CM-Preparing for ICD-10-CM

Non-HIM Impact Areas

- Scheduling –precerts, eligibility.
- Claims submission with scrubber – both ICD 9 and ICD 10 codes (Min-1 yr ability to rebill, do duality with IT systems.)
- Medical necessity CPT codes – software, manual processes, cheat sheets
- Recurring accounts – will need new precerts & recoded after 10-1-2014
- Payer acceptance of new ICD 10 codes PLUS ICD 9 codes – 2 batches
- Payer contract language – Dx codes
- Payer remark codes/denial codes
- CDM – Hardcoded RT/LT needs to match with the soft coded RT/LT ICD10
- Trauma registry - translated
- All IT systems within the organization
- 837/835 HIPAA transaction sets – new for ICD 10 locators
- Quality of care indicators – translated
- P4P indicators/Outcome Measures – translated
- Decision Support, utilization patterns, benchmarking – translated
- Medical care review – by provider, by dx, by LOS
- New business plan research/future healthcare trends – translated
- Monitoring and analyzing the incidence of disease & other health problems –translated & new
- Accepting lower case****.
- Revise forms to include new ICD 10 codes.

Who Needs to Understand ICD-10?

- Beyond the coders…
- PFS leadership as payers may reject based on ICD -10 coding and medical necessary codes & denial software.
- PFS leadership and contracting to ensure contracts can accept both ICD-9 and ICD-10 on the UBs post go live.
- UR and all care mgt as payers will need to be able to do pre-certifications and concurrent review with ICD-10.
- Decision support and all areas using ICD-9/10 coding for tracking, reporting, etc. (Trauma registry, Tumor registry, outcome comparisons, contracting, etc.).
- IT leadership must be involved to ensure all impacted areas are ready. A team leader or leaders are identified.

Payer Readiness - Letters with timelines to get started, test, dialogue

- UB submissions with ICD-9 and ICD-10 - conversion dates
- Denials with new reasons –as ICD-10 is far more specific
- Contract language that addresses ICD-10 inclusions/exclusions
- Claim scrubbers/payer scrubbers – ABN issues (LCD/NDC dx codes), ‘if ‘ rules, edits
- Pre-authorization process/coverage
- WC and Liability are not subject to HIPAA standard transactions. Will they convert?

More On LCD/NCD Diagnosis Codes Under ICD-10

- The Challenges…
- What? For each Lab NCD, the ICD-9-CM codes and descriptions will have to be translated to ICD-10-CM versions.
- When?
  - (A) Prepare preliminary versions of ICD-10-CM translations of Lab NCDs by end of January 2011 (for use in testing system functions)
  - (B) Prepare ICD-10-CM versions for full ICD-10-CM implementation in 2014

LCD/NCD Objectives and Goal

- Translate all ICD-9-CM codes and descriptors in each Lab NCD's table of covered codes to the ICD-10-CM equivalent(s).
- Provide these translated tables to the CMS contractor, so that the tables can be incorporated into the 'codelist spreadsheet' which will be processed for use by the shared systems for claims processing. (update 2/13-NCDs available)
- Goal: Allow consistent and "seamless" transition of claims for providers of laboratory test services.

Duality of Systems

- Will payers, vendors (claim submission and scrubber) and other IT systems be able to handle ICD-9-CM as well as ICD-10-CM and ICD-10-PCS at the same time?
- Rebills of pre-conversion, medical necessity software, scrubbers, ensuring all payers are ready to convert AND test with each payer = critical to the successful conversion.
- P.S. Don't forget all payers (Medicaid too!)

Hot Spots

- Make a master list of all vendors who currently support any ICD-9 activity. (Think Y2K)
- Look at all items /ordering tools where ICD-9 codes are present. Need reviewed and revised
  - Lab requisitions
  - Online ordering of services that also requests ICD-9 codes
  - Physician super bills/encounter forms with pre-printed ICD-9 codes
  - Dept specific ‘cheat sheets’ for covered dx. (Yep we know you have them!)

Example of 200 Bed Hospital IT list

- 3M or other encoder
- Main frame /main IT system
- Radiology-doc billing, radiology's own system
- Clearing house/claims
- Hospital employed doctor's software for billing
- SNF/RUG software for grouper
- HH/HHRG software for grouper
- Lab – pathology doc billing, lab's own system
- Internal electronic medical record used for coding
- Software used for Trauma & Tumor registry
- Decision support
- Scheduling software
- All tied Medical Necessity software in different areas – main frame, bolt on software, individual areas screening
- Infection Control software
- Cardiology – EKG system
- Itemized statements with dx as needed by the payer/pt
- Clinical quality reporting software
- Cheat sheets in each dept!
- OR software
- Occupational Med software

What is ICD-10-CM/PCS?

WHEN is Implementation?

- January 1, 2012 – Compliance date for implementation of electronic transactions X12 version 5010 (claims, eligibility, authorizations).
- October 1, 2014 – Compliance date for implementation of ICD-10-CM and ICD-10-PCS.
- IP date of discharge on or after October 1, 2014.
- OP date of service on or after October 1, 2014.
- No grace period and/or extension per CMS! REALLY??

The Code Freeze-Still Unknown

- On October 1, 2012, there will be only limited code updates to both the ICD-9-CM & ICD-10 code sets to capture new technologies and diseases.
- On October 1, 2013, there will be only limited code updates to ICD-10 to capture new technologies and diseases.
  - There will be no updates to ICD-9-CM, as it will no longer be used for reporting
- On October 1, 2014, regular updates to ICD-10 will begin.
- Note! No Coding Clinic guidelines…yet

Diagnosis Coding (ICD-10-CM) Building The New Code

ICD-9-CM vs. ICD-10-CM

ICD-9-CM

- 3 - 5 digits or characters
- 1st character is numeric or alpha (E or V codes)
- 2nd – 5th characters are numeric
- Decimal placed after the first 3 characters
- 17 Chapters and V & E codes are 'supplemental'
- **14,000** diagnosis codes

ICD-10-CM

- 3 - 7 digits or characters
- 1st character is alpha (all letters used except "U")
- 2nd – 7th characters can be alpha or numeric
- Decimal placed after the first 3 characters
- 21 Chapters and V & E codes are 'not' supplemental
- **69,000+** diagnosis codes

Why Are There So Many Diagnosis Codes?

- Greater specificity and detail in all diagnosis codes
- 34,250 (50%) of all ICD-10-CM codes are related to the musculoskeletal system
- 17,045 (25%) of all ICD-10-CM codes are related to fractures
  - 10,582 (62%) of fracture codes to distinguish ‘right’ vs. ‘left’
- 25,000 (36%) of all ICD-10-CM codes to distinguish ‘right’ vs. ‘left’

New to ICD-10-CM…

- Injuries are grouped by anatomic site rather than by type of injury.
- Diseases of the sense organs (eyes & ears) have their own chapters, no longer part of Nervous System chapter.
- Inclusion of trimesters in obstetric codes (and elimination of 5th digits for episode of care)
  - O99.013 Anemia complicating pregnancy, third trimester
- Change in timeframes specified in certain codes
  - Acute myocardial infarction – time period changed from 8 weeks to 4 weeks
- Full code titles for ALL codes (no reference back to common fourth and fifth digits).
- Post-op complications have been moved to procedure-specific body system chapters.

ICD-10-CM
(Injury and External Cause Extensions)

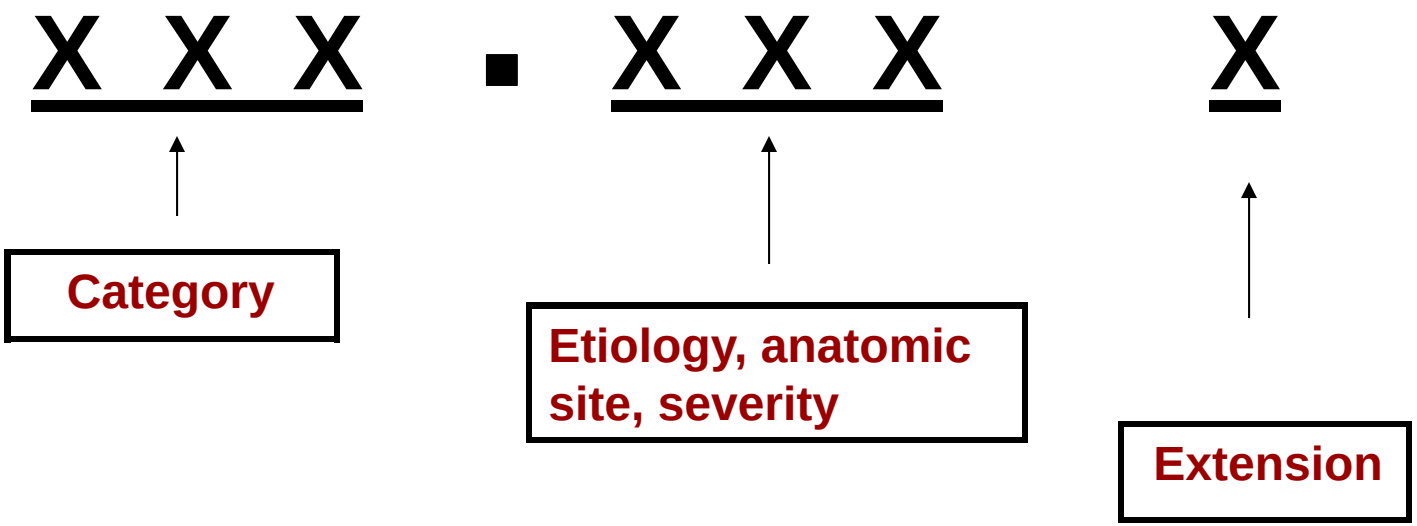
A Initial encounter

D Subsequent encounter

Q Sequelae (disease progression)

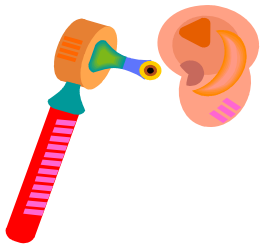
- Coders will need to look for the episode of care. Is this the patient's first visit for treatment or is it for routine follow-up?

ICD-10-CM Format



Examples of ICD-10-CM (ER)

- I10 Essential (primary) hypertension
- S01.02xA Laceration with foreign body of scalp, initial encounter
- S01.02xD Laceration with foreign body of scalp, subsequent encounter
- S01.2xxA Fracture of nasal bones, initial encounter for closed fracture
- H65.01 Acute serous otitis media, right ear (CDM edit)
- H65.02 Acute serous otitis media, left ear
- H65.03 Acute serous otitis media, bilateral



Cross Walking - GEMs

- CMS has created GEMs (General Equivalence Mappings) to assist hospitals with cross walking ICD-9-CM to ICD-10-CM/PCS “forward mapping” & ICD-10-CM/PCS to ICD-9-CM “backward mapping”. The correlation between the 2 code sets for some codes is fairly close, but not a straight correlation for others, i.e. OB.
- Not a 1 to 1 crosswalk from ICD-9-CM to ICD-10-CM. (www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp)
- GEMs are a tool to convert data.
- Available on CMS’s website.

GEMs

ICD-9-CM Code	Diagnosis	ICD-10-CM Code
V20.2	Routine infant or child examination	Z00.129 (Encounter for routine child exam without abnormal findings). Z00.121 (Encounter for routine child exam with abnormal findings). "Use additional code(s) to identify abnormal findings".
250.00	DM w/o complications, type II or unspecified	E11.9 (Type II DM without complications)
V04.81	Need for prophylactic vaccination and inoculation	Z23 (Encounter for immunization). "At this time in ICD-10-CM there is only one code for immunizations".
401.1	Hypertension, benign	I10 (Essential [primary] hypertension). "ICD-10-CM does not differentiate between hypertension that is controlled or uncontrolled, benign or malignant and there is only one code".
427.31	Atrial fibrillation	I48.0 (Atrial fibrillation) I48.1 (Atrial flutter)
786.50	Chest pain, unspecified	R07.0 (Chest pain, unspecified). "ICD-10-CM expands upon chest pain symptoms and unspecified code may no longer be necessary".
465.9	URI	J06.9 (Acute upper respiratory infection, unspecified)
724.2	Lumbago	M54.5 (Low back pain)
466.0	Bronchitis, acute	J20.0 (Acute bronchitis, unspecified). "ICD-10-CM includes 10 choices for acute bronchitis".
729.5	Limb pain	M79.604 (Pain in right leg)

Procedure Coding (ICD-10-PCS)

ICD-9-CM vs. ICD-10-PCS

- ICD-9-CM (Volume 3)
  (Procedures)
  - Min. characters: 3
  - Max. characters: 4
  - Numeric format (+ V code)
  - Decimal point
  - 3,000 procedure codes
- ICD-10-PCS
  (Procedures)
  - Min. characters: 7
  - Max. characters: 7
  - Alphanumeric format
  - No decimal point
  - 72,081+ procedure codes

ICD-10-PCS Structure (Characters and Values)

- A character is a stable, standardized code component
  - Holds a fixed place in the code
  - Retains its meaning across a range of codes

- A value is an individual unit defined for each character

Section **Body System** **Root Operation** **Body Part** **Approach** **Device** **Qualifier**

Case # 1
Diagnostic Colonoscopy

- This 44-year-old male patient is known to have diverticulitis of the colon. He has noticed melena occasionally for the past week. The initial impression was that this is acute bleeding from diverticulitis. Patient was scheduled for colonoscopy. Colonoscopy identified the cause of the bleeding to be angiodysplasia of the ascending colon.

Case # 1
ICD-10-CM Coding

- K55.21 Angiodysplasia of colon with hemorrhage (569.85)

- K57.32 Diverticulitis of large intestine without perforation or abscess without bleeding (562.11)

Case # 1
ICD-10-PCS Coding

- 0DJD8ZZ Inspection of Lower Intestinal Tract, via Natural or Artificial Opening Endoscopic (45.23)

What Will ICD-10 Cost?

Estimated Costs

- CMS estimates cost to the private sector for implementation of ICD-10 will exceed $130 million.
- Hay Group White Paper in 2006 estimated cost for hospitals ranged from $35K - $150K for < 100 beds, to $500K to $2 million for 400+ beds.
- AAPC indicates current documentation = 50% could be coded.
- AHIMA indicates after ICD 10- coders will be 50% slower for up to 3 months ++ 50% more physician queries.

Potential Hidden Costs

Potential Hidden Costs

- Back log of uncoded claims with ICD-9 while trying to get coders ready for ICD-10. Remote/outsourced coding may need to occur as well as OT.
- Rejected claims from payers who are not ready to accept UB-04 with ICD -10 PLUS ICD-9 as necessary.
- Vendor software rejecting ICD-10 or edits not working correctly thus slowing claim submission. Manual intervention to ensure claims are submitted and accepted.
- New software if existing software for related ICD-10 work is not compatible.

More Hidden Costs

- Cost to conduct a 'risk assessment' to assess current documentation patterns for providers and care givers.
- Potential salary adjustments for the coders.
- Cost to conduct training for providers and care givers on enhanced documentation.
- Cost to review EMR or other software to adapt to enhanced documentation requirements.
- Cost to conduct a 'readiness assessment ' pre go live to determine readiness of coders, documentation and vendors.
- Cost of moving 'related' work from the coders during training period. (EX: Drug administration/charge capture)

And More ….

- Loss of productivity – rebills, denials, rejections, EOB work, medical necessity rejections/follow up (PFS+)
- Loss of productivity – excessive physician queries, coder slow down with new coding process (HIM)
- Growth in the discharged not final billed…
- Potential impact to the Case Mix Index
- Cost of a project manager (1 yr contract staff to coordinate all the IT, testing, training, documentation assessments)
- Cost of implementing a clinical documentation improvement program
- Cost of EMR changes and training of all impacted staff
- Cost of any changes to the functionality of the any software and training costs

Shortage Projections AHA & AHIMA

Type	ICD 9/minutes	ICD 10/minutes
Inpt acute care	8.99	15.99
Outpt acute care	4.18	9.03
Physician practice	3.04	6.70
Free standing ASC	2.27	4.82
Nursing/SNF	6.71	12.98
Rehab facility	4.97	10.94
Additional time projected by CMS	2 minutes additional for each encounter	30% estimated loss in productivity

Shortage Strategies

- Mentorship program /formal
- 30% less productive – alternatives?
- Back fill with remote coding
- Explore Computer Assisted Coding –uses natural language processing, cost analysis
  - Outpt ancillary –high potential usage. (MN screening)
  - Other outpt areas – depending on how well the provider is documenting new elements of ICD 10. (Queries)

Education

- AHIMA estimates approximately 16 hours of coding training is needed for outpatient coders and 50 hours for inpatient coders.
- Additional time may be needed to refresh anatomy & physiology fundamentals.
- Learn foundational knowledge before more intensive training.
- Allow time for practice, practice, practice (key!)
- Down time during training and practice time.
- And don’t forget the NON-HIM training needs

What’s Next?

Developing an ICD-10 Implementation Team

- **When** ? By late 2012
- **Who**? Key leaders in the revenue cycle/IT and HIM. Will a designated project leader need identified?
- **What**? Create master list of all revenue cycle areas, IT, HIM and physician issues
- **How**? Identify timelines for when components will be done, who does it, results reviewed, testing, with ownership and timelines for completion
- Key benchmarks for completion done beginning 1st Q 2014 or once final go live date is established
- After go live, complete a 2nd set of benchmark assessments with barriers, delays, more education, etc.

Develop Phase 1 and Phase 2 Attack Plan

- Phase 1: Goal: 1st Q 2013
- Awareness training of leadership
- Awareness training of coders – inpt/all others/providers
- Conduct a risk assessment of current documentation patterns
- Track and trend ALL queries for a defined period of time.
- Using the query, develop provider education –with structured rollout time frames
- Develop master list of impact areas – coders, PFS, IT, providers, etc.
- Develop structured coder education –based on type of pt.

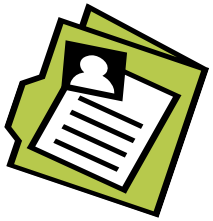
- Phase 2: 1st Q 2014-beyond go live.
- Conduct a readiness assessment –audit of documentation, testing of coders/per pt type, review of all IT functions, new forms, software testing, payer, contracting, etc.
- Coding comparison for case mix impact, MS-DRG..
- Aggressively code all pending ICD-9 prior to Oct, 2014.
- Remote/outsourced coding before/during transition and training needed
- Contract coding company should have a 'preparedness plan"
- Contract ICD-10 program manager or dedicated staff (Think Y2K)

Steps to Implementation - Communication

- Make a master list of all software where ICD-9 is being used. This will be essential to the seamless implementation of ICD-10 (or less anguish).
- Contact each vendor NOW to identify their roll out plan for compliance and when they will be ready to test.
- Test with each vendor early in 2014 or as soon as they are available for testing.
- Keep Sr. Leadership well aware of the status of ALL software testing and compliance. Be prepared to make changes if compliance is not achieved with testing 9 months prior to go live.

Audits of Course!

- Documentation Audits
  - Your CDI (Clinical Documentation Improvement) department can start now conducting ICD-10 documentation audits this year – risk assessments of current documentation practices.
  - Audit top 25 ICD-9-CM principal diagnosis codes and map to ICD-10-CM codes and begin auditing to determine whether the records contain the necessary clinical information to support the ICD-10-CM principal diagnosis code.
- Coding Audits
  - Target certain inpatient cases for review based on the MS-DRG assignment or the CC's because both of these IP PPS components will undergo changes when reconfigured with the ICD-10-CM codes.



October 2013 & Beyond

- Possible decrease in cash flow due to:
  - Increase in time to code medical records
  - Learning curves, potential increase in errors
  - Decreased coder productivity, when, or will it recover
  - System, vendor or software issues
  - Potential reimbursement impact due to payer systems, claim edits or processing issues
  - Expect denials and underpayments
  - Lower DRGs or IP lack of ‘severity of illness’ due to nonspecific documentation and unspecified diagnosis codes

Defense for 2014

Defense for 2014

- Never too late to start!!
- Provide adequate system and coding resources for ‘go live’
  - Will you need additional coding support? Contracted coders? Who will handle the coding of ‘prior to’ accounts vs. ‘go live’ accounts? Possible concurrent coding?
- Post ‘go live’ auditing & monitoring of:
  - Coding & Documentation ⇧ coding queries!
  - Systems, data, reports
  - Claims (UB & 1500), payments, denials
- Audit and then more auditing from a RISK to a READINESS environment…

Remember, we are ALL in this together!!

Accreditation for Coders

- AAPC (American Academy of Professional Coders)
  - Certified coders will have opportunity to take the ICD-10 proficiency exam starting in October 2012 and must successfully complete the test by September 30, 2014.
  - AAPC will require its certified coders to pass this test to retain their certification.

- AHIMA (American Health Information Mgmt. Association)
  - Continuing education hours with ICD-10-CM/PCS content will be required based on the specific AHIMA credential(s).
    - RHIA - required to have at least **6** CEUs dedicated to ICD-10-CM/PCS
    - **12** for the CCS-P credential
    - **18** for the CCS credential, etc.

Resources

www.ahima.org/icd10

www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm

www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/08_ICD10.asp

www.cms.gov/ICD10

www.who.int/classifications/icd/en

www.cms.gov/ICD10/Te110/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=descending&itemID=cms1246998&intNumPerPage=10

- CMS Sponsored Teleconference "Case Study in Translating Lab NCD" (5-18-11) PowerPoint slides #23 & #24

Questions ?

THANKS A TON! We are having fun now!

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Physician Documentation

Biggest Challenge?

- Documentation = Physicians!
- Begin providing them education now so that they are fully prepared on what will be required for appropriate documentation for correct ICD-10 code assignment and MS-DRG assignment.
- Customize the training for physicians based on their medical specialty.
- Do not just focus on inpatient diagnoses and/or procedures but also on outpatient diagnoses as this will require 'beefed' up documentation from your docs as well to support the codes.

Coder's Role

- As a "basic awareness":
  - Coders are required to code to the highest degree of specificity, ***but*** the quality of the physician documentation ***HAS*** to be there in the medical record.
  - Coders are bound by many rules/guidelines for application of the translation process of narratives to numerical codes, which generates the bill/claim.
  - Coders are not licensed to make the diagnoses, so if it is not stated, it cannot be coded!

Top 10 Documentation Tips

1. Laterality (side) i.e., left or right – 25,000+ codes!
2. Stage of Care, i.e., initial, subsequent, sequelae
3. Specific Diagnosis
4. Specific Anatomy
5. Associated and/or Related Conditions
6. Cause of Injury
7. Documentation of Additional Symptoms or Conditions
8. Dominant vs. Non-dominant Side
9. Tobacco Exposure or Use
10. Gustilo-Anderson scale

Fracture Coding…

- A 35-year-old man suffered open displaced tibia and fibula fractures of the right leg as the result of an automobile accident. In addition, he lost a lot of blood, also from the right leg.
- To assign the correct ICD-10-CM codes, coders will need to know:
  - Which leg and which specific bone(s) the patient injured (in this example, it's the right tibia and fibula)
  - Whether the fracture is open or closed (in this case, open)
  - Whether the fracture is displaced (in this case, displaced)
- For open fractures, coders will also need to know what type of trauma the patient suffered to choose the appropriate character based on the Gustilo-Anderson classification system.
- The 7th character identifies open fractures using the Gustilo-Anderson classifications, which are the most commonly used classifications for open fractures. The Gustilo-Anderson classification identifies the severity of the soft tissue damage.

What is Gustilo-Anderson scale?

- "Classification of fractures" – may be new to your coders and physicians
  - Type I: Wound is smaller than 1 cm, clean, and generally caused by a fracture fragment that pierces the skin (low energy injury).
  - Type II: Wound is longer than 1 cm, not contaminated, and w/o major soft tissue damage or defect (low energy injury).
  - Type III: Wound is longer than 1 cm, with significant soft tissue disruption. The mechanism often involves high-energy trauma, resulting in a severely unstable fracture with varying degrees of fragmentation.

Physician & Documentation Challenges

- Weaknesses
  - Lack of understanding of what will be required for “specificity” of documentation.
  - Need to ensure detailed documentation is present in the medical record.
  - Will see a significant increase in the # of coding queries coming their way for further clarification and/or specificity of diagnoses as documented in the medical record.
  - Need to be part of the “TEAM” as they will ‘drive’ the coding process.
  - Docs will now be affected in their own offices and must change how they document, i.e. superbill, lab requisitions

Examples of "GOOD" Documentation

- Fracture (type, site, cause)
  - Closed fracture, right arm, due to osteoporosis
- Additional Symptoms or Conditions
  - Extremity atherosclerosis with:
    - Intermittent claudication
    - Rest pain
    - Ulceration
    - Gangrene
  - Diverticulitis or diverticulosis with:
    - Peritonitis/abscess
    - Perforation
    - Bleeding
    - Location, i.e. small or large intestine

And A Few More…

- Bucket, handle tear of lateral meniscus, current injury, right knee
- Internal bleeding hemorrhoids
- Barrett's esophagus with low grade dysplasia
- Pressure ulcer of right ankle, stage II
- Mild persistent asthma with status asthmaticus
- Alzheimer's disease, early onset
- Benign neoplasm of right ovary
- Strain of right Achilles tendon, subsequent encounter

Coding Queries

- Expect a significant increase in the # of queries that will be generated from ICD-10.
- Existing coding queries will most likely have to be updated as you will be asking for different documentation to capture “specificity”.
- Make sure they are not ‘leading’ the physician to document one way or another.
- Consider making the query part of the permanent medical record – physician addendum.
- Track and trend for patterns. Then do more Ed!

Reduce Rework, Engage At Time Of Coding, Think Outside The Box!

- Think concurrent inpt coding.
- Immediate interaction with the provider and other caregivers on weak or incomplete documentation.
- Have coders on the floor with the care team. Back office coding results in ‘chasing’ the provider = delay in coding = delay in cash.
- Expand the CDI team…to include both UR needs/severity of illness & intensity of service PLUS specificity/laterality/ and other unique
- ICD-10 needs as identified thru queries and risk audits.

What Impact Will ICD-10 Have On MS-DRG Payments?

- Lack of 'specificity' for a certain diagnosis as documented in the record, could have the potential of not capturing the CC/MCC which could result in a lower paying MS-DRG.
- MS-DRG shifts could occur due to improper training of the coding staff.
  - Example: Coder selects the improper root operation for a code, i.e. excision vs. resection.
  - This incorrect code assignment could also potentially cause changes within the MS-DRGs resulting in payment increases or decreases.