ICD 10 CM BASICS, VALUE-BASED PURCHASING & CASE PRESENTATIONS

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ICD 10 CM Basics: The ICD-9 &10 codes are maintained in Volumes 1 and 2 by CMS. Volume 1 is referred to as the 'Tabular Index' as it contains a numerical list of codes for diseases and symptoms. Volume 2 is the 'Alphabetical Index" with diseases and symptoms listed alphabetically. The codes can be downloaded without charge at the CMS website: http://www.cdc.gov/nchs/icd/icd10cm.htm

The most noticeable change for the clinician is that the code categories start with a letter. The most relevant code categories for the neurologist are: "G"- Neurology, "I"- Cerebrovascular" and "R"- Symptoms and Signs. Each code can have a minimum of 3 and a maximum of 7 characters (as opposed to a maximum of 5 in the ICD-9). The first character of each code is always alpha, A-Z. The third digit can be either alpha or numeric, but the remainder are always numeric. Use of the available digits is important to indicate the complexity of the patient that is increasingly linked to estimation of severity in a way that can potentially determine reimbursement.

The means of coding varies from large practices in which a professional coder derives ICD codes from the documentation in the note to smaller practices in which the treating professional must indicate the ICD codes via paper or computer entry. Whatever means you choose, two guiding principles are suggested:

1. *'Doctor code thyself'*- just as the doctor is ultimately responsible for all aspects of care, we are also responsible for ICD coding. If it is the wrong code, we will either not get reimbursed in a timely fashion or could be accused of fraud. We are responsible so it is to our advantage to get the code right, even if that means directing the professional coder to the correct category. As physicians we are in the best position to accurately code the disease and severity.
2. *'Documentation, Documentation, Documentation'*- our clinical notes must reflect our thinking regarding how we arrived at the diagnostic code. This is required not only by a person we may pay to do the coding, but also by a CMS or third party payer auditor. Fortunately, most neurologists do this very well as part of our clinical practice.

The AAN provides crosswalks to members on its website for the most common neurological diagnoses www.aan.com/practice/billing-and-coding/icd-10-cm/

A note on technology: Modern electronic health records (EHR) frequently provide assistance with coding options. Some use drop-down lists and others are based on word searches. For those systems that do not provide coding assistance within the EHR, a variety of third-party, apps can provide codes on your computer (e.g. http://www.icd10data.com/ (an example, not an endorsement) and smartphone (e.g. https://itunes.apple.com/us/app/icd10-codes/id413924956?mt=8; https://itunes.apple.com/us/app/icd-10-virtual-code-book/id644580329?mt=8; https://play.google.com/store/apps/details?id=br.com.trofo.cid10&hl=en; https://play.google.com/store/apps/details?id=com.findacode.free.icd&hl=en (examples, not

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endorsements). However, whatever method you use, be aware that these are far from perfect and make sure that the code reflects the correct clinical diagnosis.

Value-based Purchasing: A detailed discussion of this very important topic is beyond the scope of this syllabus, but is available on the Center for Medicare & Medicaid Services website at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html and https://qpp.cms.gov/.

A few important concepts to consider when reviewing this material (which will also be introduced in the course:

- The name of the program has changed from MACRA to the Quality Payment System (QPP)
- The two categories of reimbursement models are: Merit-based Incentive Program and the Advanced Alternative Payment Models
- Previous value-based programs (e.g. Physician Quality Reporting System) have been eliminated, but with several similar objectives within QPP.
- Your performance in the year 2017 will determine the payment adjustment you receive in the year 2019

Optimal ICD 10 coding of common neurological disorders

Korwyn Williams MD, PhD

While the roughly 5–fold expansion in the number of codes with the transition from ICD-9-CM to ICD-10-CM is daunting, little has changed with the organization of codes used by neurologists. Aside from the alphanumeric codes and "encounter codes," the approach to coding has not changed. To avoid denials and potential audits, it is worthwhile to become more familiar with the nuances of ICD-10-CM. There is a greater emphasis on capturing specificity supported by the documentation, whether that is the diagnosis, lateralization of disorders, or issues complicating management and treatment. Through clinical scenarios, best practices of ICD-10-CM coding will be reviewed, focusing on potential pitfalls and opportunities for improvement.

How to Avoid and Respond to Denials

David Evans MBA

The transition to ICD-10 is fully behind us, including any grace periods that CMS provided to ease the burden of costly claim denials and processing delays. In reviewing statistics pre- and post-ICD-10 implementation, there are some encouraging findings; for the year ending 9/30/2016 as compared to the prior 12 months, the average payer processing time dropped from 20 days to 15, according to RemitDATA®. Although this data is encouraging, denials remain one of the most significant areas of lost revenue for providers and healthcare organizations. CMS reports that ~2% of claims were denied for having incomplete or invalid information following the end of the grace period, which is comparable to pre-ICD-10 levels. However, of all claims processed by CMS, 10.1% were denied, with the most common reported denials being use of an invalid ICD-10 code, non-specific ICD-10 code, and lack of medical necessity for services rendered.

This session will provide an overview of the most common coding denials and best practices in workflow and clinical documentation to ensure maximum reimbursement for services rendered. It will also include tools to assess your denial rate with targeted approaches to mitigate denials at initial claim submission

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