Apollo 13
- 7th manned mission in the American Apollo space program
- Mission – land on the moon
- Launched April 11, 1970
- Lunar landing aborted after an oxygen tank exploded 2 days later and crippled the Service Module upon which the Command Module depended
- Crew relied on Lunar Module as a lifeboat for survival
  - Designed for 2 men for 2 days but it needed to support 3 men for 4 days

Apollo 13
- Hardships caused by limited power, loss of cabin heat, shortage of potable water and jury-rigging of the carbon dioxide removal system
- Safely returned to earth April 17, 1970

Cast – Hollywood Style
- Commander – James Lovell
  - “Houston, we’ve had a problem…”
- Command Module Pilot – John “Jack” Swigert
  - Wasn’t even supposed to be there
  - Replaced Ken Mattingly
- Lunar Module Pilot – Fred Haise
- Lead Flight Director – Gene Kranz
  - Ordered the abort of the mission
Supporting Cast – Hollywood Style

- Flight Controllers, Support Personnel, Ken Mattingly, engineers and designers, University of Toronto
- NASA Administrator – Thomas Paine
  - “There has never been a happier moment in the US space program. Although the Apollo 13 mission must be regarded as a failure, there has never been a prouder moment in the US space program.”

Cast – Nursing Home Style

- Commander – (Tom Hanks)
  - Billing Manager
- Command Module Pilot & Lunar Module Pilots – (Kevin Bacon & Bill Paxton)
  - Billing Staff
- Lead Flight Director – (Ed Harris)
  - Director of Finance or CFO
- Flight Controllers/Support Personnel/Ken Mattingly, etc. – (Gary Sinise and many recognizable others)
  - Staff from nearly every other department
- NASA Administrator
  - President or CEO or Administrator

Apollo 13 Hardships

- System Failures
  - Electrical system failures
    - Without power in CM it was cold – 38 degrees
    - Couldn’t rest so fatigue kept them from functioning properly
    - Condensation problems could cause electrical shortages
  - Environmental system failures
    - LM not equipped to handle the load of filtering the carbon dioxide which created an O2 concern
    - Filters between the modules were incompatible
    - NASA, employees, contractors used what was on hand
    - “What do we have on the spaceship that is good?”

- Needed to find the fastest route home which meant using gravity of the moon to sling shot them back toward earth
- 2 course corrections required
  - Miscalculation would either skim them across the atmosphere and back into space or they would burn up on re-entry
  - Done with slide rules!
- Hardships interfered with each other
What’s The Relevance to Nursing Homes?

- Apollo 13 was NASA’s most successful failure
- NASA was ready for all kinds of disasters but this was their first chance to prove it
  - Able to think about things that were way outside the procedures they practiced, run through checklists, use their imagination and come up with ways to very calmly work out the best way to bring three people back to Earth alive

If your Business Office is NASA what is it prepared to do as it relates to Medicaid Managed Care and ICD10?

System Failures

- General Lack Of Understanding
- Pre-Billing Issues
  - Contracting
  - Credentialing
  - Enrollment
  - Insurance Verification
  - Authorizations

Determine Route Home

- Understand the Contract & Provider/Billing Manual
  - Billing format
  - Billing system
  - Timely filing
  - Appeals
  - Payment Accuracy
System Failure: General Lack of Understanding

- More new terms and acronyms for many employees
  - MMCP – Medicaid Managed Care Plan
    - Managed care version of Medicaid
    - Mandatory for most Medicaid recipients – dual eligibles are excluded
    - Now covers LTC (effective 2/1/15)
  - MAP – Medicaid Advantage Plus
    - Traditional insurance model for age 18+, intensive case management model
    - If required to enroll in MLTC may choose to enroll in a MAP
    - Must enroll in the plan’s Medicare product
    - Long term care and health services coverage

Fee-for-Service (FFS) vs. Managed Care

<table>
<thead>
<tr>
<th>Who does Medicare or Medicaid pay?</th>
<th>Who does provider bill?</th>
<th>Permission needed for services?</th>
<th>Policy – incentive to give too much/little care?</th>
<th>What package of services is available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pays each provider for each service rendered</td>
<td>Provider bills Medicare or Medicaid directly</td>
<td>Sometimes, Medicaid – need approval for PCS, CDPAP, etc.</td>
<td>Incentive to bill for unnecessary care offset when authorization is needed for services</td>
<td>All Medicare and Medicaid services</td>
</tr>
<tr>
<td>Pays a flat monthly fee (capitation) to insurance plan</td>
<td>Bills the Managed Care plan which pays from a monthly capitation rate from Medicare or Medicaid</td>
<td>Often. Plan may require authorization to see specialists or for many services. May not go out of network.</td>
<td>Plan has incentive to DENY services and keep part of capitation rate for profit</td>
<td>Package of services may be “partial” (MLTC) or “full” (PACE = all Medicare and Medicaid services)</td>
</tr>
</tbody>
</table>
Options if ONLY have Medicare OR Medicaid

<table>
<thead>
<tr>
<th>Insurance Status</th>
<th>Fee for Service</th>
<th>Managed Care Model</th>
</tr>
</thead>
</table>
| Have Medicare only | Medicare Advantage plan usually covers Part D  
- Voluntary but 30% of Medicare beneficiaries join  
- Pros: Cheaper than a Medigap premium and controls other out-of-pocket costs  
- Cons: Must be in-network and obtain plan approval |
| Have Medicaid only | Medicaid Managed Care  
- Mandatory for non-dual eligibles  
- Covers primary, acute and long term care |

System Failure: General Lack of Understanding

Phase-In Schedule

<table>
<thead>
<tr>
<th>Month</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 1, 2015 Phase 1</td>
<td>New York City – Bronx, Kings, New York, Queens, Richmond</td>
</tr>
<tr>
<td>April 1, 2015 Phase 2</td>
<td>Nassau, Suffolk, Westchester</td>
</tr>
<tr>
<td>July 1, 2015 Phase 3</td>
<td>All other counties</td>
</tr>
<tr>
<td>October 1, 2015</td>
<td>Voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid</td>
</tr>
</tbody>
</table>

Contracting

- Many facilities not yet prepared to handle contract reviews  
  - Identify contracting spokesperson and team – include billing, nursing, prior authorization, medical department, etc.  
  - The Bonadio Group working with groups across NY State to form IPA’s (which includes contract review)  
    - Non-IPA related contract reviews can be done as well |
- Rate – 3 year current FFS (benchmark) rate or negotiated rate  
  - If previously negotiated rate: pay benchmark during transition unless other arrangement is agreed to  
    - Does billing know what the rate should be?
System Failure: Pre-Billing Issues

Contracting

- Pharmacy Services – Unless otherwise negotiated: “During transition MCO must accept NH’s current arrangement with pharmacies for residents placed in NH post 8/1/14.”
- If a resident is receiving a pharmaceutical not on MCO formulary (s)he can continue to receive it for 60 days post enrollment into plan
- Reimbursement covered thru Medicaid pharmacy program and therefore billed outside of benchmark rate
- Benchmark continues to include OTC, J-codes, medical supplies, nutritional supplements, sickroom supplies, adult diapers and DME
- Benchmark continues to include immunization services inclusive of vaccines and administration

System Failure: Pre-Billing Issues

Contracting

- Bed hold methodology – unless otherwise negotiated, MCO required to follow current Federal/State Medicaid bed hold regulations (CFR 483.12 and 10YCR 415.8 and 18NYCRR 505.9)
  - LOA for temporary hospitalization – 50% reimbursement
  - LOA for non-hospitalization – 95% reimbursement
  - Payment for temporary hospitalization and health care professional therapeutic visit LOAs may not exceed 14 days in any 12 month period
  - Payment for LOAs other than temporary hospitalizations and health care professional therapeutic visits may not exceed 10 days in any 12 month period
  - Must have been resident for at least 30 days and unit to which recipient will return has a vacancy rate of no more than 5%

System Failure: Pre-Billing Issues

Contracting

- NAMI collection – initial implementation shifts responsibility to MCO and MCO may delegate it to NH or other entity
  - Should be outlined/agreed to during contracting
  - Make sure you have an internal process in place if agreement is different than the current norm
  - LDSS will notify plan and NH of NAMI amount when re-budgeting is complete.
  - Long term plan – State or designee will assume financial and operational responsibility to distribute NAMI and collect NAMI income.

System Failure: Pre-Billing Issues

Contracting

- Billing / Payment cycle – During transition MCOs have indicated a willingness to allow the submission of clean claims from NH at least every 2 weeks (bi-weekly) or twice a month
  - Not mentioned in provider/billing manuals
  - Don’t make assumptions
  - Billing department needs to change current processes
- Admission authorization requirements
  - If enrolled in a plan, MCO must authorize all long term care placements and will pay the NH while long term eligibility is being conducted by LDSS
- “End-of-life” considerations
In order to minimize administrative burdens on NHs and MCOs it was decided that NHs must adhere to Federal and State laws as it relates to credentialing staff.

Recommended that MCOs consider delegating credentialing to NH’s. If delegated:

- MCO must have process to verify that the NH has completed the required credentialing
- MCO should minimize additional credentialing requirements

Model contract between MCO and State requires MCO to have a formal re-credentialing process (not less than once every three years).

NCQH (National Committee for Quality Assurance) sets “THE” standards.

Credentialing Process

- Application (credentialing form)
- Initial Screening (for completeness)
- Site Visit
- Primary Source Verification (PSV)
- File Preparation (for presentation to Credentialing Committee)
- Data Entry (in MCOs credentialing database)
- The Decision (to accept or reject application)
- Re-credentialing

System Failure: Pre-Billing Issues

Overview of credentialing requirements

- Valid and current licensure
- Clinical privileges
- Valid DEA
- Appropriate education and training
- Board certification
- Appropriate work history
- Malpractice insurances
- History of liability claims

Re-credentialing includes reviewing information from:

- National Practitioner Data Bank (NPDB)
- State Board of Medical Examiners
- Medicare/Medicaid Programs regarding sanctioning
- Complaints
- Quality Improvement/Utilization Management activity reports
- Medical records reviews
- Attestations from practitioner regarding his/her ability to perform the essential functions of the position and use of illegal drugs
- Verify from the primary source the information that was checked at the time of credentialing
Credentialing

Overview of credentialing organizational providers
- MCO must have policies and procedures for initial and ongoing assessment of organizational providers with whom it contracts
- MCO must confirm provider is
  - In good standing with state and federal regulatory bodies
  - Has been reviewed and approved by an accrediting body
    - If not approved – must implement standards of participation
- MCO must re-credential provider at least every three years by confirming the above

Delegated Credentialing

- So what part is supposed to be delegated to the NH?
  - Portion of the credentialing process, such as primary source verification (PSV)?
  - Multiple processes such as collection and review of the application and PSV?
  - All credentialing activities?
- MCO must evaluate NH’s ability to perform the activities
- Need mutually agreed upon document describing MCO’s responsibilities vis-à-vis the delegated entity
- MCO must annually evaluate delegated entity’s performance

Questions to ask yourself
- Is delegation all it is cracked up to be?
- Can you meet delegation requirements?
- Will you sub-delegate?
  - Contract with a third party to perform a delegated function
    - PSV can be delegated to a CVO (Credentials Verification Organization)
    - If CVO is NAQH certified – NH/MCO is exempt from due-diligence oversight
- If not delegated
  - Is CAQH UPD (Council for Affordable Quality Healthcare Universal Provider Datasource) utilized by payer?
  - What providers will need to be credentialled?
  - Do you have contracts for professional services and will those providers need to be credentialled and become participating providers?
    - Who is responsible for ensuring credentialing is completed?
  - Quality scores will most likely be requested during facility credentialing/re-credentialing
**Credentialing**

Who will complete forms and monitor credentialing progress?
- Time consuming – Already overworked billing staff?
- If other department, must communicate status with billing

Understand contract/payment implications of rendering care before credentialing is completed:
- If payer will back date:
  - Enter charges and hold claims, OR
  - Wait to enter charges – will they get lost?
- If payer won’t back date:
  - Render care knowing no payment?

---

**Enrollment**

Enrollment – newly eligible and not in an MCO
- Coming from home to NH: Apply for Medicaid following all current regulations, including physician recommendation, PASRR process, Patient Review Instrument (PRI), etc.
- LDSS has 45 days to complete determination for long term Medicaid eligibility
- Once approved and any penalty period has elapsed and NAMI amount is identified resident has 60 days to choose an MCO
- Medicaid Choice (Maximus) will assist in education, plan selection and enrollment (in a plan with which the nursing home contracts)
- Auto enrolled if not select
- No lock-in so enrollment may change

---

**Enrollment**

Enrollment – already enrolled in an MCO
- MCO must authorize all long term placements and pay the NH while long term eligibility is being conducted by LDSS
- NH and MCO assist with submitting documentation
- Member has 90 days from date long term placement is determined to submit the application for coverage of long term custodial placement to the LDSS
- LDSS will notify MCO, enrollee and NH
  - If eligible – MCO keeps paying NH and NAMI is collected
  - If ineligible – MCO recoup payment from NH and coordinate safe discharge into the community

---

**What about a community PCP?**

- Enrollees may keep PCP when transitioning from community to NH
- NH is responsible for credentialing or granting privileges but MCO is responsible to credential all providers participating in the plan
  - If NH won’t: resident may see PCP in PCP’s office in community
- All MMCP enrollees must have a PCP and enrollees may retain their community PCP. MMCP may use the NH physician but must inform DOH and ensure that the NH physician follows network responsibilities
- A transitioning resident may see their PCP for 60 days if the PCP is an out of network PCP
System Failure: Pre-Billing Issues

Enrollment
Enrollment – other considerations
✓ If a permanent NH FFS resident (prior to date of mandatory managed care) is hospitalized and ineligible for NH bed hold upon return the resident will be viewed as a new permanent placement and will be required to enroll in a managed care plan.
✓ Medicaid re-certifications – the resident or designated representative is still responsible for submitting a Medicaid recertification. NHs and MCOs are encouraged to assist.
  • If an enrollee does not appear on the plan’s 1st or 2nd roster the plan is not obligated to pay the nursing home

System Failure: Pre-Billing Issues

Insurance Verification
Medicare, Medicare Advantage Plan, Medicare Part D, Supplemental Plans, Medigap, Commercial Plans, Medicaid, Medicaid Managed Care, Medicaid Long Term Care….
✓ Dual Eligible with original Medicare, Medicare Part D, Medigap and MLTC will have 5 insurance cards

System Failure: Pre-Billing Issues

Insurance Verification
Internal Considerations
✓ Provider must check eligibility at the time of service and before billing
  • Currently may not be checking eligibility before billing now
  • Is this going to be a new process?
  • Will you do it for all payers?
  • Who is going to do it?
  • What resources will they use?
Insurance Verification

How to verify

- ePACES
  - Carefully look at eligibility codes (institutional Medicaid, spend down)
  - Follow up as needed
- Medicare Common Working File
  - Check for each resident – not just Medicare Part A admissions
  - CWF isn’t always correct – follow up on inconsistencies
- Payer websites or phone calls to each insurance
- Clearinghouse insurance verification portal

Best Practice Suggestions

- Staff training
- Identify type of coverage (MA, MLTC, Dual Advantage, MAP, etc.) AND name of plan (to be able to easily reference payer manuals)
- Document every call/contact in your billing system
- Verification completed before admission and billing

Authorizations

- UAS-NY assessment completed by MCO – required when individual enrolls in a plan and every 6 months thereafter or when significant change in condition occurs
- MCO required to compare the UAS-NY assessment needs with the MDS assessments conducted by NH and consider both when authorizing services, equipment and supplies
- The care plan, MDS, UAS-NY, medical record and input from care management team will provide the MCO with the information needed for authorization of services
- Although reassessment using UAS-NY is required at above schedule, MCOs may authorize for shorter time periods

- Always verify if an authorization is needed and for what services – admission, routine, elective, urgent
- Requirements are MCO specific
- MCO may require prior authorizations for some plans and services but not others
- Document contact person and telephone numbers for future extensions and reassessments during insurance verification
- When is re-authorization required? What form? Portal or paper?
System Failure: Pre-Billing Issues

**Authorizations**
- Will current authorization staff be able to handle future volume?
- Coordination between billing and prior authorization staff
  - When/how/does billing get the authorization number?

Obtaining authorizations will become more complicated and time consuming

Determine Route Home

**Billing Format**
- Every new format creates added work
  - Claim format will be similar to Medicaid format because need rate code
  - Claim format may be similar to HMO because you need authorization number
  - What rate is used
    - UCC, Medicaid or negotiated?
- Look at each plan and determine if a new claim format needs to be built
  - Requires testing

<table>
<thead>
<tr>
<th>Description</th>
<th>Revenue Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Hold – Temporary Hospitalization</td>
<td>0185</td>
</tr>
<tr>
<td>Bed Hold – Therapeutic LOA</td>
<td>0183</td>
</tr>
<tr>
<td>Bed Hold – Other Therapeutic LOA</td>
<td>0189</td>
</tr>
<tr>
<td>Room and Board + Ancillary Services</td>
<td>0190, 0191, 0192, 0193</td>
</tr>
<tr>
<td>Room and Board Only</td>
<td>0190, 0191, 0192, 0193</td>
</tr>
</tbody>
</table>

Determine Route Home

**Billing System**
- Consider the structure/design of your billing system
  - If only have Fidelis as a financial class it may be insufficient because there may be multiple Fidelis plans (not just MLTC plans) in your area and each plan is likely to have different claim requirements
- Can my billing system easily produce a “clean” claim?
  - How many human interventions are needed to get a clean claim?
- Electronic or paper submission? Direct Data Entry (DDE)?
  - All MCOs must be able to accept electronic claims
- Need to submit multiple batches of claims to multiple payers
  - No longer just 1 weekly batch to Medicaid
  - More time needed for submission and acceptance monitoring
Billing System
- Consider all managed care (not just Medicaid):
  - How does system handle rate variations within the same plan for level of care billing (higher rates for additional therapy utilization or nursing care)?
  - Can rates be loaded so contractual adjustments calculated at billing will result in $0 balance when payment is posted?
  - Are your contractual allowances correct for each plan/payer?
- Can system produce payer and plan specific billing reports?
- Need to focus on structure, tables, dictionary modifications?

Timely Filing
- Know timely filing requirements for each payer
  - Most payers have a 90 day timely filing rule
  - Bill at least monthly – no later than the 15th
  - Bill as often as payer will allow
- Maximize MCO billing cycle
  - For Example: Medicaid Cycle
    - Start date = Thursday, 6/25/15
    - End date = Wednesday, 7/1/15
    - Check date = Monday, 7/6/15 (2 business days after end date)
    - Check release date = Wednesday, 7/22/15 (3 weeks after end date)

Appeals
- Know each MCOs appeal process for each type of appeal
  - Time limits
  - Specific forms
- Review your process for each type of appeal
  - Who gathers the necessary documents?
  - Who submits?
  - Who monitors status?
  - Are outcomes shared with all?
  - Are you learning from denied appeals?
### Appeals

<table>
<thead>
<tr>
<th>Payer and Plan</th>
<th>Appeals/Disputes/Reconsiderations (on-line Provider Manuals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fidelis Care</td>
<td>Medical necessity appeal - Submit within 60 days&lt;br&gt;Administrative denial reconsideration (timely filing, co-insurance, eligibility, lacking pre-auth, other errors on claim, underpayments) - Submit within 60 days&lt;br&gt;Timely filing - penalty of up to 25% may be imposed</td>
</tr>
<tr>
<td>WellCare</td>
<td>Timely filing, incidental procedures, bundling, unlisted procedure codes, non-covered, etc. - Submit within 6 years of the date of denial</td>
</tr>
<tr>
<td>VNSNY CHOICE – MCAre and MCaid Advantage Plans</td>
<td>Disputes resulting from claim adjustments or denials: Standard reconsideration request – denial of payment or medical necessity – per contract</td>
</tr>
<tr>
<td>VNSNY CHOICE – Medicaid MLTC</td>
<td>Disputes resulting from claim adjustments or denials: Standard reconsideration request – denial of payment or medical necessity – per contract&lt;br&gt;Request for denial of payment due to claim coding – Submit within 90 days&lt;br&gt;Request for denial of payment due to no authorization – Submit within 90 days</td>
</tr>
</tbody>
</table>

### Payment Accuracy

#### Underpayment Concerns
- Losing out on money

#### Overpayment Concerns
- Are you sure it’s not your money?
- Refunds required - processing costs time and money
  - Issue check?
  - Request retraction
  - Recoup from future remittance
Course Corrections

Billing Department Changes

✓ Staffing re-design
  • Current silo structure used in many NHs will become ineffective
  • Eventually it may be too much work for one person to handle
  • Consider alpha-split or shift additional FTE to managed care billing
✓ Implement a clearinghouse
  • Vendor that serves as a middleman between facility and MCO for claims submission and payment processing
  • Improves efficiency and facilitates other valuable revenue cycle services
✓ Modifications to billing calendar

Communication

✓ Internal
  • All must understand key components of plan and how they impact reimbursement and care coordination
  • Contract, provider manuals, billing manuals available to all
  • Summary of each plan needed for all
✓ External
  • Families – enrollment status and NAMI collection
  • MCO – provider representatives, monthly meetings, billing training

Clinical Implications

✓ Authorizations/notifications for transfers and other care services (routine, elective, urgent)
  • Clinical staff will have to coordinate with payer case manager for nearly every resident
  • Significant increase in time
✓ Coordination with vendors/suppliers
  • More time required to coordinate coverage and benefits
✓ Clinical Appeals
  • More time spent by clinical, HIM, others
✓ Documentation changes needed?
System Failures
- New Coding Structure
- Implementation Plan Parts 1 and 2
  - Planning
  - Communication

Determine Route Home
- Implementation Plan Parts 3 and 4
  - Testing
  - Training

Course Corrections
- Complexity
- Prior Level of Function
- MDS
- Clinical Workflow
- Triple Check
- Billing Plan

System Failures
- New Coding Structure effective October 1, 2015
  - Differs from ICD-9 in organization and structure, code composition and level of detail
    - ICD-9 code has 3 – 5 digits
    - ICD-10 code has 3 – 7 digits
    - ICD-10 more specific and more complex
      - ICD-9: Usually a # but can be letter E of V in 1st digit
      - ICD-10: 1st digit is letter (not U); 2nd digit is #; remaining can be letter or number
    - ICD-9 ~ 15,000 codes versus ICD-10 ~ 64,000 codes
Implementation Plan

CMS recommends a 20 month implementation timeline.

CMS Small Hospitals / Small – Medium Practices

Part 1 - Planning
- Implementation Strategies
- Cross-Functional Team
- Detailed Time Line
- Risk Assessment
- Budget

Part 2 - Communication
- Plan
- Collaborate (team effort)
- Tools/Checklists
- Information dissemination
- Evaluate current vendors and payers

Planning

Implementation Strategies
- How will you accomplish this?
- What must be done?
- How will you do it?
  - Interviews, surveys, walk-throughs, documentation reviews, IT system inventory
- How long will each step take?

Cross-functional team
- Nursing, providers, billing, therapy, HIM, IT, finance, compliance, etc.
- Long time employees and new hires
- Leader how has time to dedicate to daily monitoring
- Executive involvement
  - We are great at having meetings and saying this is how we will do something but then we fail by not having the necessary follow up
System Failures

Planning

✓ Detailed timeline

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Kick-off Sheet</td>
<td>Sample created and reviewed by team 3/2/15 (Lab). Sent to IT on 3/4/15 (file), IT received and sent on 3/11/15 (file)</td>
</tr>
<tr>
<td>Initial Kick-off Letter</td>
<td>To be placed on bulletin board in staff lounge and in pharmacy. Sample approved by team on 3/2/15 (Done). Printed and ready to go 3/4/15 (Done). Hang up on bulletin board 3/4/15 (Done). To be reissue 3/1/15 for next pay day (Done). In 3/12/15 psychology (Done)</td>
</tr>
</tbody>
</table>

Risk Assessment

- Follow a resident through admission, all services, billing, payment
- Identify each revenue cycle process that utilizes a revenue code
- Will likely result in changes to clinical and administrative systems and processes
- Will likely result in changes to resident care processes and staff member workflows

Budget

- What are the costs and will charged to each department?
- IT assessment
- Education and awareness and related productivity loss
- Impact to productivity
  - Up to 50% reduction in coding in first months
  - Clinical/medical providers will spend ~15% more time asking questions, observing and documenting
- Impact to cash and A/R
  - 3 – 6 month post implementation financial impact
System Failures

Planning

✓ Budget
  • Software modifications – education, testing, staff time
  • Temporary/Contract staff – increased work, coding/billing backlogs, IT support, coding reviews
    • Time needed to identify assistance, execute engagements
  • New report design, reprinting paper forms
  • Data conversion – maintenance of dual code sets, additional software/tools (electronic mapping)
  • Other projects competing for resources (financial/personnel)

System Failures

Communication

✓ Plan
✓ Collaborative Effort
  • Include staff, business associates, vendors, outsourced therapy providers, physicians/NP/PA, payers
✓ Tools/Checklists
  • CMS GEMS
    www.cms.gov/Medicare/Coding/ICD10
  • Munson Healthcare/Trinity Health
    www.munsonhealthcare.org/icd10/tips

Determine Route Home

Implementation Plan Parts 3 and 4

✓ Part 3 - Testing
  • Test plan
  • Hardware/Software
  • Identify test data
  • Identify test scenarios
  • Conduct internal and external testing
✓ Part 4 - Training
  • Training/Education plan
  • Evaluate educational needs
  • Types of training
  • Documentation improvement opportunities

System Failures

Communication

✓ Information Dissemination
  • Kick-off
  • Emails blasts
  • ICD10 Q&A dedicated email
  • Updates
✓ Evaluate current vendors and payers
  • Are they ready? Can they provide it?
Testing

- Test Plan
  - Who, when, how, clearinghouse
- Hardware/Software
  - All that involve revenue cycle including interfaces
- Identify test data
  - All payers if possible
- Identify test scenarios
  - R&B, therapy, ancillary, professional, 3 – 7 digits codes

Internal/external testing

- Internal
  - Can you create a claim
  - Can you use ICD9 and ICD10 simultaneously
- External
  - Can you submit a claim
  - Payers have begun testing – have you?

Training

- Plan
- Evaluate educational needs
  - Who – coders, providers, billing, clinical, administrative, managements, compliance, others?
  - Assess current level of education/experience
  - Assess level of knowledge by role and based on duties

Type of Training

- What type and level of training for each job role
- Determine best method
  - Webinars, seminars, consultants, computer-based, emails, lunch/learn, shift training, weekends
- Basic Users: Admissions, Clerical/Technical staff
- Clinical Users: IT, Billing, Quality, Sr. Management, Contract Managers, Compliance, Data Analysis
- Documentation: Physicians, NP/PA, Nurses, Ancillary Department Managers, MDS Coordinators
- Super Users: Coders, Auditors, HIM Directors
Training

Basic Users
- General information and impact across revenue cycle and what they need to know for transition (1–4 hours)

Clinical Users
- Need to understand impact of documentation (3–8 hours)

Documentation
- Key to success (4–12 hours)
- Providers – consistent education 15 minutes at a time
- Nurses – charting will need clearer details of problems, assessments, procedures and treatments

Super Users – depending on facility, this could include providers
- In depth knowledge
- DHHS recommends inpatient/hospital coders ≈ 50 hours
- DDHS recommends outpatient coders ≈ 10 hours
- AHIMA recommends experienced coders ≈ 16 hours

Start dual coding in June/July 2015 – at least a few hours daily

Educational resources
- World Health Organization, AHIMA, AAPC
- Area hospitals and health systems, payers
- ICD-10-CMMPUdepartment@anthem.com
- EMR/billing systems

Documentation improvement opportunities
- Conduct documentation assessments – determine adequacy of documentation to support new required level of detail
- Implement documentation improvement plan
- Identify unspecified ICD9 codes used now
- LCDs – on NGS website (Medical Policy & Review tab)

Alzheimer’s Disease
- ICD-9 = 1 code
  331.0 – Alzheimer’s

Course Corrections
- ICD-10 = 4 codes
  G30.0 – Alzheimer’s disease with early onset
  G30.1 – Alzheimer’s disease with late onset
  G30.8 – Other Alzheimer’s disease
  G30.9 – Alzheimer’s disease unspecified

If applicable also code:
- F05 – Delirium
- F02.81 – Dementia with behavioral disturbance
- F02.80 – Dementia without behavioral disturbance
ICD-9 = 1 code
781.2 – Abnormality of gait
ICD-10 = 4 codes
R26.0 – Ataxic gait
R26.1 – Paralytic gait
R26.89 – Other abnormalities of gait and mobility
R26.9 – Unspecified abnormalities of gait and mobility

ICD-9 = 9 codes
707.00 – 707.09
707.0 Pressure Ulcer
707.01 – unspecified site
707.02 – upper back
707.03 – lower back
707.04 – hip
707.05 – buttock
707.06 – ankle
707.07 – heel
707.09 – other site

ICD-10 = 125 codes
L89.0 – L89.94
L89.131 – Pressure ulcer right lower back, Stage I
L89.132 – Pressure ulcer right lower back, Stage II
L89.133 – Pressure ulcer right lower back, Stage III
L89.134 – Pressure ulcer right lower back, Stage IV
L89.139 – Pressure ulcer right lower back, unspecified stage
L89.141 – Pressure ulcer left lower back, Stage I

ICD-9 = 40 codes
250.00 – 250.93

ICD-10 = 211 codes
E08 Range – Diabetes due to underlying condition (43 codes)
E09 Range – Drug or Chemical induced Diabetes (43 codes)
E10 Range – Type 1 (41 codes)
E11 Range – Type 2 (41 codes)
E13 Range – Other specified (43 codes)

Expanded to include not only site and location of fracture but also the laterality and type of fracture
- V54.13 (aftercare following hip fx (ORIF) has approximately 150 codes in ICD10
- Open/closed; anatomical site; displaced/non-displaced; laterality; routine healing or delayed healing; nonunion or malunion; and sequel
- Hospital an initial encounter for a patient with a displaced, closed fx of the greater trochanter of the R femur would be coded S72.11A (initial encounter). But when admitted to the SNF for rehab the code would be S72.11D which indicates subsequent encounter with routine healing.
Certain Injuries

- Cause of injury, where injury occurred, what resident was doing when the injury occurred, external cause status (work related, military, other)

  - But this is only an issue for initial treatment
  - Example: Resident sustains an injury and is seen by the MD who is rounding that day. The professional services claim will need these codes, but they won't necessarily be needed on the R&B claim

MDS

- RUG classification is largely based on major disease categories, not ICD9 codes.

  - Section I: Active Diagnoses
    - 14800 Dementia
    - 13900 Hip Fracture
    - 14200 Alzheimer's Disease
    - 15300 Parkinson's Disease
    - 12000 Pneumonia
    - 10700 Hypertension

  - Must list additional active diagnoses (use ICD code)
    - Section I: 18000 Additional active diagnoses

Clinical Workflow

- As documentation requirements increase, nurses may need to reconsider the care delivery model and workflow.

  - Are there administrative tasks that can be delegated?
  - Are there tasks that can be shifted to a different time of day?
  - Does current care model optimize time at the bedside?
  - Can you streamline a workflow?

Month-end Triple Check

- Nursing/therapy/billing compare claim to the medical record and all supportive documentation

  - Includes: RUG scores, HIPPIS, service dates match ARD, admission dates, DOS, 3-day qualifying hospital stay, therapy minutes and therapy days, diagnoses, physician (re)certification, revenue codes, ancillary services, etc.

  - UB04 is a "mini" medical record
    - Coded in accordance with coding guidelines for ICD-9/10 and must support coverage, medical necessity and services rendered

  - UB04 codes need to be added to MDS Section 18000 Additional active diagnoses or vice versa?
  - Need to coordinate MDS diagnoses with UB04 diagnoses and update with each submission

  - Increased ICD10 detail = an increased risk of inconsistencies in UB04, MDS, rehab evals and choosing incorrect code
Course Corrections

Month-end Triple Check

✓ Routinely see facilities that do not hold month-end triple check meetings
✓ Routinely see claims with outdated diagnosis codes
  • Speech therapy related diagnosis codes but no speech therapy services rendered
    - Diagnosis code carried over from prior claim
  • Pneumonia for 9+ months
  • 1st code should be diagnosis that requires resident to be in SNF
  • No changes in diagnosis codes after Part A cut
✓ Consider triple check for Part B claims

Billing Plan

✓ Need plan to enter ICD10 codes in billing system for all existing residents as of 10/1/15
✓ Billing forms CMS1500 and UB04 require use of indicator to show whether ICD9 or ICD10 codes are used
✓ Develop a claims submission contingency plan
  • Manual entry into FISS (OmniPro), ePACES, other
  • Logons/passwords, training, needed?
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