DISRUPTIVE CODING CHANGES IN THE BEHAVIORAL HEALTH INDUSTRY: A CPT, ICD, AND DSM OVERVIEW

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• Uniform language accurately describing medical, surgical and diagnostic services (provided) under public and private health insurance programs

• Not subject to a lot of change: 2013 was an exception (30)

• Nuances: Modifiers, Add-On’s, Levels and Complexity, Medical-Decision-Making, Time Override options, and more

• Different subsets of CPT codes:
  • Psychotherapy
  • HCPCS Healthcare Common Procedure Coding System, based on CPT codes, 5 digit-alpha numeric
  • Evaluation and Management: Physician-Patient encounters (E & M, E/M); increasingly more complex over time, documentation standards
Changes for provision of psychotherapy services are “not major” compared to coding and billing for psychiatric and medical services.

Two new codes distinguish between:

- An initial evaluation with medical services provided by a physician (90792)
- An initial evaluation provided by a non-physician (90791)
**Interactive Psychotherapy Is Now Interactive Complexity/Add-On Code**

<table>
<thead>
<tr>
<th>Communication difficulties such as:</th>
<th>Mental Health Provider must overcome barriers by utilizing:</th>
<th>For Recipients Who Are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Anxiety</td>
<td>Play Equipment</td>
<td>Not fluent in the Providers language</td>
</tr>
<tr>
<td>High Reactivity</td>
<td>Physical Devices</td>
<td>Not developed or lost skills needed to use or understand typical language</td>
</tr>
<tr>
<td>Repeated Questions</td>
<td>Interpreter/Translator</td>
<td></td>
</tr>
<tr>
<td>Disagreement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver Interference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discovery/discussion about 3rd party reporting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### E & M Coding Considerations

#### Patient/Place Status
- New or Established Patient
- Office/Outpatient/Hospital Inpatient

#### Levels of Care
- Level 1: Office Visit, Est. patient, minimal encounter
- Level 2: Office visit, Est. patient, limited/minor concerns
- Level 3: Office visit, Est. patient, low-moderate severity
- Level 4: Office visit, Est. patient, “routine care”
- Level 5: Office visit, Est. patient, moderate-high severity

#### Time
- IF the visit is predominately counseling or care coordination in nature, use TIME. Time may be the overriding factor for established patients.
- Counseling/Care Coordination represent 50% or more of the encounter, use TIME
- The Clinical Record has special requirements when using TIME (start/stop times)
- 5 minutes to 40 minutes are typical slots
Components Of E & M

Each individual code listed has three components that qualify physicians to work for the specific code:

1. History
2. Examination
3. Medical Decision Making (MDM) Refers to the complexity of establishing a diagnosis and/or selecting a management option

There are then three components to document:

1. Risk to patient
2. Amount and complexity of data
3. Diagnosis

Documentation Requirements: CMS guidelines, “work done”, and “medical necessity”
...And For All That Extra Work?

- In November 2013: Anthem BCBS in CA stated:

“Specifically, we have experienced claims processing system errors as a result of the new codes that might have affected the payments you received for services provided since January 1, 2013 and but also might have resulted in incorrect and/or multiple deductibles and co-payments for your patients. This problem is being addressed with the highest priority.”
County Mental Health Departments = “Mental Health Plans” (MHP’s)

- Came away with more questions than answers
  - Why does every county have to do this own thing?
  - Who made these decisions?
  - Will the State give ONE standardized crosswalk for codes to the counties?
  - What happens to standardization, provider/government/organizational efficiencies, and above all: How does this affect THE CONSUMER?? *

*Trickle down effect to the Consumer.....
Counties, MHP’s and Carve-Outs

- Medi-Cal beneficiaries with serious mental health needs that cannot be met within a primary care physician’s scope of practice receive specialty mental health services and supports that are administered by counties. These services are often described as “carved out” because they are not provided by the Medi-Cal managed care plans, but are provided by counties instead because of their specialized nature. (58 counties)

- County mental health plans (MHPs), which are the county mental health departments throughout the state, perform this function under the state’s Specialty Mental Health Services (SMHS) Consolidated Medicaid Waiver.

“Really? Are the counties better able to manage the overall healthcare of an individual with SMI than a health care plan?”

ACO’s?
Counties, the ACA, and Market Trends

• The **Affordable Care Act** emphasizes coordination of care
• Market trend is to TAKE BACK the carve-out, bring it in-house in order to comply with healthcare reform initiatives (ACO’s)

  “So, wouldn’t it then make sense to put the management of the SMI population BACK into the hands of health care plans who have the capability to better integrate medical/BH?”

• HIPAA makes it difficult to share MH information with physical health providers; chronic health conditions exacerbate MH conditions

  “So, the very system that is in place perpetuates disconnection, a lack of coordinated care, and dysfunction.”

42 CFR conflicts with Triple Aim
The California System: County Codes & 2014 Update

- Counties: use their own coding structure and crosswalks (perpetuates a lack of standardization)
  - Mental Health Mode of Service/Service Function Codes are *mapped* to HCPCS codes (Local Carrier Codes OR Local Codes)

**Psychology Services Local Code Conversion:** Effective for dates of service on or after January 1, 2014:

- HCPCS local codes for psychology services are *terminated and replaced* with specific CPT-4 Codes and Revenue Codes
- Effective for dates of service on or after January 1, 2014, the following HCPCS local codes for psychology services are *terminated* with no replacements
- Effective for dates of service on or after January 1, 2014, the following CPT-4 codes are to be used according to the test performed with suggested Revenue Code 0918*
- January 2014: Providers should not use the 2014 codes to bill for Medi-Cal, EWC and Family PACT services until notified to do so in a future *Medi-Cal Update*

- [http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/psy201311.asp#a1](http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/psy201311.asp#a1)
Coding Changes: Frame of Reference

![Diagram showing the relationship between DSM, CPT, ICD, and Revenue Disruption]
The ICD-10: International Standards

- WHO 1893; currently on Version 10; working on Version 11
- New medical conditions, knowledge, treatments, and devices since 1975 (ICD-9)
- Research, monitoring performance, understanding disease, public health tracking and more

- Naming and Coding System that is more accurate, standardized and specific
  - Understand the encounter better AND account for other conditions: genetic, nutrition, blood alcohol

- The ICD-9/10 is the only diagnostic code set that is HIPAA compliant = Reimbursements, 837s, HCFA’s
“What About The DSM?”

- Many people are not aware they were “using” ICD-9 codes for Claims
- ICD is foreign to most BH/SU clinicians
- DSM IV-TR to DSM 5 is a wake-up call
- DSM 5 attempts to align with ICD-10, but it is not exactly aligned
- We Will Need BOTH Manuals
CMS on DSM-5 and ICD-10

• “In current practice by the mental health field, many clinicians use the DSM-IV in diagnosing mental disorders. As of May 19, 2013, the DSM-5 was released. Can these clinicians continue current practice and use the DSM-IV and DSM-5 diagnostic criteria?”

• Yes. The Introductory material to the DSM-IV and DSM-5 code set indicates that the DSM-IV and DSM-5 are “compatible” with the ICD-9-CM diagnosis codes. The updated DSM-5 codes are cross walked to both ICD-9-CM and ICD-10-CM. As of October 1, 2014, the ICD-10-CM code set is the HIPAA adopted standard and required for reporting diagnosis for dates of service on and after October 1, 2014.

• Neither the DSM-IV nor DSM-5 is a HIPAA adopted code set and may not be used in HIPAA standard transactions. It is expected that clinicians may continue to base their diagnostic decisions on the DSM-IV/DSM-5 criteria, and, if so, to crosswalk those decisions to the appropriate ICD-9-CM and, as of October 1, 2014, ICD-10 CM codes. In addition, it is still perfectly permissible for providers and others to use the DSM-IV and DSM-5 codes, descriptors and diagnostic criteria for other purposes, including medical records, quality assessment, medical review, consultation and patient communications.

• Dates when the DSM-IV may no longer be used by mental health providers will be determined by the maintainer of the DSM-IV/DSM-5 code set, the American Psychiatric Association, http://www.dsm5.org
DSM-5 versus ICD-10 Clinical Descriptions and Diagnostic Guidelines

- **DSM-5:**
  - Contains the clinical descriptions in the book
  - Is very good at describing conditions, symptoms, criteria, timelines, etc
  - Has some very nice assessment tools in it

- **ICD-10:**
  - ICD-10 Tabular Index is the precise way of coding diagnoses
  - But the Tabular Index does not contain clinical descriptions
  - Clinical Descriptions and Diagnostic Guidelines are contained in the “Blue Book”
WHO’s ICD-10 “Blue Book”

• Chapter 5’s “Clinical Descriptions and Diagnostic Guidelines”
• “Not likely used here in the US”
• American Psychological Association on the Blue Book (May 2013):
  • Psychologists can use the Blue Book to determine diagnoses. Be aware, however, that many users find that this document does not have the same level of detail that the DSM(5) contains (APA’s opinion).
  • Other clinical descriptions and diagnostic guidelines could also be used to arrive at a diagnosis. As noted, the ICD is the code set used for classification and billing purposes, but the ICD itself does not contain extensive criteria for the purposes of diagnosis. It is presumed that the health care professional has that knowledge, or access to that knowledge, and the expertise to use that knowledge appropriately.
**Upcoming Diagnostic Problems**

- **ICD-10: MANY more diagnoses to choose**
- **Will require more details and specificity in documentation**
- **No exact crosswalk between code sets**
- **Will involve clinical judgment, thought, and time**
- **Steep learning curve, even for experienced staff**
- **Some payers/States still want DSM for PA’s or other purposes**
## ICD-9 Versus ICD-10: Details

|--------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|
| 14,000 codes  
Cannot keep up with medical discovery, knowledge, and treatments  
No longer supported by WHO | 68,000 codes  
Fundamental overhaul increasing digits, codes, alpha-numeric, improved granularity  
WHO supported |
| 3-5 digits  
Limited Combination Codes  
2 Volumes, 17 Chapters | 3-7 digits  
Extensive Combination Codes (thus digit expansion)  
3 Volumes, 21 Chapters  
Chapter 5: Mental and Behavioral Disorders |
| Expansion is limited or full | Room to expand without future overhauls (placeholders = “x” for 6th and 7th digits) |
| Not descriptive enough | Significantly more specific and will accommodate future health care needs |
ICD-9 To ICD-10 Specificity Example: The “One-To-Many” Concept

<table>
<thead>
<tr>
<th>295.70 Schizoaffective DO, Unspecified State</th>
<th>F25.0 Schizoaffective disorder, bipolar type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F25.1 Schizoaffective disorder, depressive type</td>
</tr>
<tr>
<td></td>
<td>F25.8 Other schizoaffective disorders</td>
</tr>
<tr>
<td></td>
<td>F25.9 Schizoaffective disorder, unspecified</td>
</tr>
</tbody>
</table>

Note: not an exact match from I-9 to I-10. Source: 3M EnCoder
Examples of Expanded Diagnoses in DSM-5 and ICD-10

• We must use both manuals, therefore YOU must know both manuals

• Schizotypal states and Delusional disorders have been expanded

• Bipolar disorder, category F31 also expanded

• Substance Use codes contain the most expansion
  • DSM-IV-TR has 9 diagnoses involving Cannabis
  • DSM-5 has 22 diagnoses involving Cannabis
  • ICD-10 has 44 diagnoses involving Cannabis
<table>
<thead>
<tr>
<th>ICD10-CODE</th>
<th>ICD10-Description</th>
<th>DSM5</th>
<th>DSM5 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F10.121</td>
<td>Alcohol abuse with intoxication delirium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F10.221</td>
<td>Alcohol dependence with intoxication delirium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F10.921</td>
<td>Alcohol use unspecified with intoxication delirium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F10.231</td>
<td>Alcohol dependence with withdrawal delirium</td>
<td>F10.231</td>
<td>Alcohol withdrawal delirium</td>
</tr>
<tr>
<td>F10.96</td>
<td>Alcohol use, unspecified with alcohol-induced persisting amnestic disorder</td>
<td></td>
<td>Alcohol-induced major neurocognitive disorder, Amnestic confabulatory type: F10.26 w/mode</td>
</tr>
<tr>
<td>F10.97</td>
<td>Alcohol use, unspecified with alcohol-induced persisting dementia</td>
<td></td>
<td>Alcohol-induced major neurocognitive disorder Nonamnestic confabulatory type: F10.27 with m</td>
</tr>
<tr>
<td>F10.151</td>
<td>Alcohol abuse with alcohol-induced psychotic disorder with hallucinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F10.251</td>
<td>Alcohol dependence with alcohol-induced psychotic disorder with hallucinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F10.951</td>
<td>Alcohol use, unspecified with alcohol-induced psychotic disorder with hallucinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F10.150</td>
<td>Alcohol abuse with alcohol-induced psychotic disorder with delusions</td>
<td></td>
<td>Alcohol Intoxication delirium F10.121 with mild use; F10.221 with moderate or severe use; F10.9</td>
</tr>
<tr>
<td>F10.250</td>
<td>Alcohol dependence with alcohol-induced psychotic disorder with delusions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F10.950</td>
<td>Alcohol use, unspecified with alcohol-induced psychotic disorder with delusions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F10.230</td>
<td>Alcohol abuse with withdrawal, uncomplicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F10.232</td>
<td>Alcohol dependence with withdrawal with perceptual disturbance</td>
<td></td>
<td>Alcohol withdrawal: F10.232 with perceptual disturbances; F10.239 without perceptual disturba</td>
</tr>
<tr>
<td>F10.239</td>
<td>Alcohol dependence with withdrawal, unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F10.982</td>
<td>Alcohol use, unspecified with alcohol-induced sleep disorder</td>
<td></td>
<td>Alcohol-induced sleep disorder: F10.182 mild; F10.282 moderate or severe; F10.982 without use</td>
</tr>
<tr>
<td>F10.980</td>
<td>Alcohol use, unspecified with alcohol-induced anxiety disorder</td>
<td></td>
<td>Alcohol-induced anxiety disorder: F10.180 mild; F10.280 moderate or severe; F10.980 without u</td>
</tr>
<tr>
<td>F10.94</td>
<td>Alcohol use, unspecified with alcohol-induced mood disorder</td>
<td></td>
<td>Alcohol-induced bipolar, depressive &amp; related disorder: F10.14 mild; F10.24 moderate or severe;</td>
</tr>
<tr>
<td>F10.981</td>
<td>Alcohol use, unspecified with alcohol-induced sexual dysfunction</td>
<td></td>
<td>Alcohol-induced sexual dysfunction: F10.181 mild; F10.281 moderate or severe; F10.981 without u</td>
</tr>
<tr>
<td>F10.99</td>
<td>Alcohol use, unspecified with unspecified alcohol-induced disorder</td>
<td>F10.99</td>
<td>Unspecified alcohol-related disorder</td>
</tr>
<tr>
<td>F15.23</td>
<td>Other stimulant dependence with withdrawal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F15.93</td>
<td>Other stimulant use, unspecified with withdrawal</td>
<td>F15.93</td>
<td>Caffeine withdrawal</td>
</tr>
</tbody>
</table>

There are MANY withdrawal codes; F11's, F13's, F15's, F17's and F19's for the specific drug/usage
ICD-10 Format: “Funny-Looking”

- Chapter F = Chapter 5 in ICD-10
- Category = condition or drug of choice (10= Alcohol)
- Last 4 digits represent the clinical state: etiology, severity, manifestation, and placeholders

Notes:
- S, T Codes: Injury, Poisoning
- Z Codes: Factors Influencing Health Status
- T and R Codes As Well may be applicable
Four- and five-character categories may be used to specify the clinical conditions

F1x.0 Acute intoxication
  
  .00 Uncomplicated
  
  .01 With trauma or other bodily injury
  
  .02 With other medical complications
  
  .03 With delirium
  
  .04 With perceptual distortions
  
  .05 With coma
  
  .06 With convulsions
  
  .07 Pathological intoxication

F1x.1 Harmful use

F1x.2 Dependence syndrome
  
  .20 Currently abstinent
  
  .21 Currently abstinent, but in a protected environment
  
  .22 Currently on a clinically supervised maintenance or replacement regime [controlled dependence]
  
  .23 Currently abstinent, but receiving treatment with aversive or blocking drugs
  
  .24 Currently using the substance [active
  
  .27 -dependence]
  
  .25 Continuous use
  
  .26 Episodic use [dipsomania]

F1x.3 Withdrawal state
  
  .30 Uncomplicated
  
  .31 With convulsions

F1x.4 Withdrawal state with delirium
  
  .40 Without convulsions
  
  .41 With convulsions
Recurrent Depressive Disorders F33’s (ICD-10)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F33</td>
<td>Recurrent depressive disorder</td>
</tr>
<tr>
<td>F33.0</td>
<td>Recurrent depressive disorder, current episode mild</td>
</tr>
<tr>
<td>F33.1</td>
<td>Recurrent depressive disorder, current episode moderate</td>
</tr>
<tr>
<td>F33.2</td>
<td>Recurrent depressive disorder, current episode severe without psychotic symptoms</td>
</tr>
<tr>
<td>F33.3</td>
<td>Recurrent depressive disorder, current episode severe with psychotic symptoms</td>
</tr>
<tr>
<td>F33.4</td>
<td>Recurrent depressive disorder, currently in remission</td>
</tr>
<tr>
<td>F33.8</td>
<td>Other recurrent depressive disorders</td>
</tr>
<tr>
<td>F33.9</td>
<td>Recurrent depressive disorder, unspecified</td>
</tr>
</tbody>
</table>
BiPolar’s F31 (ICD-10)

F31 Bipolar affective disorder

F31.0 Bipolar affective disorder, current episode hypomanic
F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms
  
F31.2 Bipolar affective disorder, current episode manic with psychotic symptoms
F31.3 Bipolar affective disorder, current episode mild or moderate depression
  .30 Without somatic syndrome
  .31 With somatic syndrome
F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms
F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms
F31.6 Bipolar affective disorder, current episode mixed
F31.7 Bipolar affective disorder, currently in remission
F31.8 Other bipolar affective disorders
F31.9 Bipolar affective disorder, unspecified
Persistent Mood and Remaining Affective Disorders  F34-F38 (ICD)

**F34** Persistent mood [affective] disorders
- F34.0 Cyclothymia
- F34.1 Dysthymia
- F34.8 Other persistent mood [affective] disorders
- F34.9 Persistent mood [affective] disorder, unspecified

**F38** Other mood [affective] disorders
- F38.0 Other single mood [affective] disorders
  .00 Mixed affective episode
- F38.1 Other recurrent mood [affective] disorders
  .10 Recurrent brief depressive disorder
- F38.8 Other specified mood [affective] disorders

**F39** Unspecified mood [affective] disorder
Diagnosis Confusion: Asperger's Example

**DSM-5:** Asperger's is no longer a coded disorder, having been merged into the new Autistic Spectrum Disorder.

**ICD-10:** Includes a code for Asperger's Syndrome, F84.5.

**ICD-11:** MAY replace Asperger's, but MAY NOT—no final decision has been made.
And... What About Those New DSM-5 Codes?

- Disruptive Mood Dysregulation Disorder: not listed in either ICD-9 or ICD-10

- “Exact” mapping for this DO is not available as a result

- Closest applicable ICD-10CM code would be:
  - F34.8: Mood Disorder, Other Specified

- How will your clinicians handle this?
- How will this be documented?
- Can you standardize documentation and how?
- What will the insurer pay for? What’s in your payer contract?
## Substance Use: Turf Wars Between DSM-5 and ICD-10

<table>
<thead>
<tr>
<th>DSM-5</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organized by Substance Used, but a little different than ICD-10</td>
<td>• Organized by Substance Used, but a little different than DSM-5</td>
</tr>
<tr>
<td>• Still spells out Phencyclidine</td>
<td>• Phencyclidine included in Hallucinogen category &amp; not named explicitly</td>
</tr>
<tr>
<td>• Abuse and Dependence= OUT</td>
<td>• Abuse, and Dependence = IN</td>
</tr>
<tr>
<td>• “History of”= In the DSM</td>
<td>• “History of”= Not in ICD</td>
</tr>
<tr>
<td></td>
<td>• More details:</td>
</tr>
<tr>
<td></td>
<td>• Aspects of Use: withdrawal</td>
</tr>
<tr>
<td></td>
<td>• Effects of Use: Abuse, Dependence</td>
</tr>
<tr>
<td></td>
<td>• Manifestations: …with delirium</td>
</tr>
<tr>
<td></td>
<td>• Inclusive of other conditions that affect treatment: blood alcohol level(Y90.xxx)</td>
</tr>
<tr>
<td>DSM IV TR</td>
<td>ICD-9 CM</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
</tr>
<tr>
<td>300.16 : Factitious Disorder With Predominantly Psychological Signs and Symptoms</td>
<td>300.16: Factitious disorder with predominantly psychological signs and symptoms</td>
</tr>
<tr>
<td>315.1: Mathematics Disorder</td>
<td>315.1: Mathematics Disorder</td>
</tr>
<tr>
<td>333.7: Neuroleptic-Induced Acute Dystonia</td>
<td>333.72: Acute dystonia due to drugs</td>
</tr>
</tbody>
</table>
Why is Language Important?

- Impacts clinical documentation
- Problems with Language
  - ADHD/ADD versus Hyperkinetic disorder
  - Hypochondriasis (I-10) versus Illness Anxiety DO (D-5)
  - Asperger’s
  - Abuse and Dependence
- Consistent documentation: defending audits
- Impacts systems (EHR templates, outcomes measures, metrics)
ICD-10 Get Ready!

Staff Training/Education

Testing Systems

Vendor Readiness

Crosswalks/Reference Materials

“What’s YOUR Y2K Plan?”

Payer contracts
ICD-10 Team Membership

- Clinical
- Medical
- Leadership
- Quality/Compliance
- Billing/Revenue
- Information or Applications Systems
Components of Organizational Readiness

1. Readiness Assessment: Staff, Culture and Analysis
   ICD-10, Clinical Documentation & Regulatory Attitudes

2. ICD-10 Team and Project Plan
   ICD-10 Team Communications, Training Plans
   Policy and Procedures Review

3. Testing and Systems Readiness
   Internal Systems
   External Systems
   Flow between systems
ICD-10 Transition: First Steps

Establish Your ICD-10 Team

Conduct a Systems Inventory
What Is A System?

ANY BUSINESS AND OPERATIONAL PROCESS THAT CONTAINS DIAGNOSTIC INFORMATION

You will be surprised where diagnostic information may be lurking
Internal and External Systems to Assess

- All diagnosis touch points
- Eligibility and Benefit Information Systems
- Prior-Authorization’s
- Practice Management Systems, EHR, eRX, HIE’s, Labs
- Claims and Clearinghouses
- Super bills, charge sheets, MD visits
- Child Welfare or other regulatory systems
- Reporting: public health, state, performance
- All Payers
- EHR’s: internal logic of CDS, alerts
- Business Intelligence/Analytics
- Internal databases/registries
Systems Issues to Assess

- Capable of dual coding? Submitting ICD-9 prior to October 1; ICD-10 October 1 forwards
- Any upgrades that need to happen? Account for testing time, possible glitches, and bug fixes
- Cost to you for upgrades?
- What will be the impact on the organization?
Revenue Cycle and Billing Processes: The Biggest Risk and Impact Area

- Payers
- Testing
- Risk Mitigation
Payers: Who is Doing What When?

- Everyone is doing something different at different times
  - Example: 18 payer sources = 18 different timelines
- How many payers do you have and what is their respective revenue percentage?
- Examine contracts with Payers: DSM/ICD language
- ICD-10/DSM utilization
Every system that holds, transmits, or analyzes health data will need to be modified.

- CMS on Testing: “Testing will ensure ICD-10 compliance across internal policies, processes, and systems, as well as external trading partners and vendors”
- Without thorough internal and external testing, you will have no idea if you will be ready or what will happen to your revenue income after October 1, 2015
- Two Key Factors:
  - a) Can you connect AND exchange ICD-10 information?
  - b) Can the payer handle, adjudicate, and process the claim correctly?
Testing and Risk Mitigation Strategies

- Test representative sample
- Use different code combinations (SU/BH/primary-secondary dx's)
- Emphasize testing with large pay source
- Test different provider types (MD, aide, etc)
- Test per diems, bundles, individual CPTs, etc
- Waterfall/crossover billing
- Ensure YOU can test (some restrictions here)
- Incorporating the DSM in the system
Revenue Cycle: Denial Remediation

1. What pre-existing claims problems have had with any particular payer?
2. How have they resolved claims problems in the past?
3. Have contact information: phone numbers, instructions, name of person handy
4. What is your Plan B for any particular party and how big will the “hit” be?
5. Establish a process of how denied claims get handled
6. May need 1 FTE the first 2-3 months for this
Establishing Your Training Programs

- Clinical staff:
  - understand DSM-ICD relationship, diagnosing, clinical documentation
- Billing:
  - new coding and process
- Intake/pre-registration staff:
  - basic diagnostic groups for pre-certifications
- Compliance:
  - reporting, data collection, clinical documentation guidelines, adherence, etc.
Training Details

**Training Time**
- 5-8 hours Intake/Pre-Certification
- 20-40 hours clinical staff
- 25-40 for on-site billing

**Curriculum**
- ICD-10 Basics for Everyone
- Role-specific training
- Materials to support job duties
- Screen Shots/EHR Vendor Training

**Clinical Topics**
- ICD-10 Basics
- Diagnosing (group according to program/age)
- Clinical Documentation
Level of Detail in Coding and Charting

• Diagnosis codes are to be used and reported at their highest number of characters available
  • Example: If a condition has 6 digits, then use all 6 digits AND document to account for all 6 aspects of the condition

• A three-character code is to be used only if it is not further subdivided
  • Example: Do NOT use just F10. Alcohol _NOS_? What?

• A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable
Document to Substantiate Diagnosis

• All the KEY medical concepts, relevant to care now and looking to the future
• ICD-9: Code and Description: 292.85 Drug induced sleep disorders
• ICD-10: Code and Description: F13.282 Sedative, hypnotic or anxiolytic dependence with sedative, hypnotic or anxiolytic-induced sleep disorder

• You would then write in your record:
  “A patient is evaluated for a [drug induced] [sleeping disorder] that is related to [dependence] on a [sedative drug].”
A Word About Training on BOTH Manuals

- We must learn 2 classification systems
- Denial and ignorance does not change an auditor's mind
- Make sound policy decisions
- While many of you have already completed your trainings, did you train on both manuals?
- Do not underestimate the differences, nuances of the two manuals
Contact Information

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