BlueCross BlueShield of Montana

CAPSULE NEWS℠

FOR CONTRACTING INSTITUTIONAL AND PROFESSIONAL PROVIDERS AUGUST 2015

Our ICD-10 Testing Program Summary

Blue Cross and Blue Shield of Montana (BCBSMT) has completed end-to-end or "round-trip" testing of electronic claims (837 transactions) submitted with ICD-10 codes with a select group of providers. Enrollment in the ICD-10 Testing Program was open to all interested contracted providers who met necessary prerequisites. End-to-end testing began in May 2015 and test claims were accepted through Aug. 14, 2015.

OVERVIEW

The testing process offered providers and their staff the opportunity to practice coding with ICD-10. Participants submitted "twin" claims for testing – one with ICD-9 codes and the other with ICD-10 codes. BCBSMT then processed both claims with the intention of taking all submitted and accepted test claims to a finalized status. For each finalized test claim, BCBSMT returned an 835 Electronic Remittance Advice (835 ERA). Participants also received testing summary results for each set of twin claims.

WHO PARTICIPATED?

BCBSMT testing participants included a number of clearinghouses and 12 providers (five hospitals and seven professional providers).

KEY FINDINGS OF THE TESTING PROGRAM

1. **BCBSMT can successfully receive, process and return results for claims submitted with ICD-10 codes.** We successfully tested 209 ICD-9 and ICD-10 claims and were able to process claims to completion. This included FEP and local claims, as well as six specialties across three claim types: Inpatient (28%), Outpatient (66%) and Professional (7%).
2. **Proper end-to-end functionality (837 acceptance to 835 remittance) was confirmed with one intermediary clearinghouse.**
3. **Coding behaviors seen between pairs of ICD-9 and ICD-10 are consistent with industry findings.** While most test claims showed no variance between ICD-9 and ICD-10, a small percentage of test claims showed differences that may be due to the added specificity of the ICD-10 code set, a different sequence of codes between ICD-9 to ICD-10, or coder interpretation of medical equivalence mappings.

TESTING SUMMARY

The test results were encouraging in light of the limited sample size and the number of providers and clearinghouses involved in the process. The end-to-end testing has indicated that systems at BCBSMT appear to be ready to accept and process ICD-10 claims. The end-to-end testing also indicates that major clearinghouses appear ready to handle ICD-10 claims appropriately. Additionally and according to feedback received during webinars and other outreach activities, participating providers found the testing process to be helpful in determining their readiness for the ICD-10 implementation.

Small Practice Alert

ICD-10 is really happening. It is a federal requirement that you comply, regardless of what kind of health insurance your patients have. If you haven't started getting ready, we urge you to take immediate action.

- Obtain ICD-10 coding manuals. Identify the ICD-9 codes you use most often currently and compare to ICD-10: What's the same? What's different?
- Talk to your practice management software vendor – have all updates been made?
- If you use a billing service and/or clearinghouse, talk with them, too – are they prepared to support ICD-10? If not, it may be time to find a new vendor.

LEARN MORE

The Centers for Medicare & Medicaid Services (CMS) offers readiness resources to assist you, such as their Roadto10.org site, CMS Quick Start Guide and a "Countdown to 10" video. For your convenience, we've added direct links to these resources in the Standards and Requirements/ ICD-10 section of our website at bcbsmt.com/provider. *Also see page 3 of this newsletter for information on types of training and other readiness resources.*

ICD-10 Special Edition

Benefit Preauthorization Reminders

BCBSMT will accept ICD-10 codes beginning Sept. 21, 2015, for benefit preauthorization requests for services that will be rendered on or after Oct. 1, 2015. A benefit preauthorization submitted and approved prior to Oct. 1, 2015, with ICD-9 codes will not need to be resubmitted with ICD-10 codes. Prior to submitting a benefit preauthorization request, we encourage you to check eligibility and benefits through your preferred online vendor portal.

Quick tip: Start adding ICD-10 codes to referrals and orders for future services likely to occur on or after Oct. 1, 2015. The provider receiving your referral or order often relies on your diagnosis for their own billing. If you are not sure when the future service will occur, include both ICD-9 and ICD-10 codes on your request.

Join us for a webinar! For an overview of differences you may encounter when using ICD-10 codes in iExchange®, our online benefit preauthorization tool, please join us for an iExchange ICD-10 Enhancements webinar on Sept. 16, 2015, from 1 to 2 p.m., MT. To register online, visit the Education & Reference/Training page of our website at *bcbsmt.com/provider*.

Please note that the fact that a guideline is available for any given treatment, or that a service has been preauthorized/pre-certified is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.

Good Clinical Documentation = Good ICD-10 Coding

It all begins with you and your patient. This fact will not change with the transition to ICD-10. However, a higher level of specificity in your documentation will be necessary in many instances – such as documenting laterality – to support proper assignment of ICD-10-CM/PCS codes. To help ensure that claims are properly billed and appropriate benefits are applied, your documentation must paint a clear and complete picture of each patient's condition with details to support subsequent diagnoses and treatment.

Careful documentation also is important for auditing purposes, as the patient's health record helps demonstrate adherence to quality of care measures. Medical record data is used to help develop provider report cards and to demonstrate meaningful use in electronic health records. Provider profiles may be made publicly available through online transparency or comparison tools and potential patients may use this information when they are choosing where to go for care. Additionally, accurately capturing the severity of illness may ultimately affect case management index weighting and different forms of reimbursement.

In preparation for the transition to ICD-10 coding, many providers have implemented clinical documentation improvement (CDI) programs. In fact, ICD-10 is often used to justify the return on investment of expenditures on CDI programs and staff. Clinical documentation specialists (CDSs) may also be employed to assess current documentation practices and suggest opportunities for improvement. Some provider groups may have a physician champion on staff to help facilitate communication between CDSs and medical and clinical staff as well as to provide peer-to-peer support.

CDI is relevant to the facility setting, particularly when Medical Severity DRGs are determined. CDSs often understand the potential financial impact of complicating or comorbid conditions and major complicating or comorbid conditions and can help providers ensure that their documentation supports clinically complex diagnoses. CDSs also can help review the query process between coders and clinicians and/or develop templates to help physicians gather necessary components for accurate coding assignment.

Regardless of whether your organization or office has implemented a program, there are some basic CDI principles you can use to help make your documentation ICD-10-ready:

1. **Lay the groundwork** by outlining a complete history
2. **Go below the surface** by highlighting potential red flags and risk factors
3. **Include progress notes** to illustrate how the patient was monitored and evaluated
4. **Put the pieces together** with details on why decisions were made
5. **Focus on teamwork** between medical, coding and billing staff

If you need help, the American Health Information Management Association (AHIMA) has published a quick reference guide titled ICD-10-CM/PCS Documentation Tips on their website at http://bok.ahima.org/PdfView?oid=300621. Other clinical documentation improvement tools and services are widely available.

Types of Training: What's right for you?

There are generally three types of training that most provider organizations will need, as outlined below. Whichever training program(s) you choose, try to schedule the training so that it finishes at least a week or two before Oct. 1, 2015. This will help you make any final preparations necessary to start coding in ICD-10 for dates of service/discharge date of Oct. 1, 2015, and later.

Training for physicians and clinicians – This type of training is frequently offered according to provider specialty. This type of program generally emphasizes how to document properly in the medical record so that trained medical coders can assign ICD-10 codes accurately. Training on ICD-10 code selection instruction also may be available.

Training for medical coders – This type of training is frequently offered according to provider specialty and emphasizes how to assign ICD-10 codes based on clinical documentation. Certified coders are required to have several hours of ICD-10 training to maintain their certifications. Certifications are generally specific to diagnosis codes (ICD-10-CM) or procedure codes (ICD-10-PCS) or both. All coders will need ICD-10-CM training, and inpatient hospital coders will need ICD-10-PCS training.

Training for practice managers and office staff – This type of training is less likely to be according to provider specialty. It typically focuses on more general topics, such as overall differences between ICD-9 and ICD-10, as well as preparing for challenges by developing strategies to overcome them. Some training may be specific to practice management systems, electronic health record (EHR) and/or clearinghouse system(s).

While BCBSMT cannot recommend or endorse any specific training program, we suggest you consider the following selection criteria to find an ICD-10 training program that is right for you or your practice:

1. Start with organizations where you already do business or with whom you have an affiliation.
   - If you are affiliated with a large medical group or hospital, ask if they have ICD-10 training available that you can attend or take online.
   - If you use a practice management system, EHR, billing service or clearinghouse, ask if they have ICD-10 training available to customers. Many clearinghouses have negotiated discounts on ICD-10 training for their customers.
   - If you are a member of a medical society or association, see if they are offering ICD-10 training to their members. Many have tailored training by specialty, and some offer discounted training to their members.
2. Next, look at professional medical coding associations, such as the American Health Information Management Association (AHIMA) and AAPC (formerly the American Academy of Professional Coders). These organizations have developed online and in-person training classes for specific job roles and specialties. General training information can be found at ahima.org and aapc.com. Also consider contacting the local chapters of these organizations (email or call a board member of a local chapter) and ask if they can send trainers to your location.
   - For Montana, there is one local chapter of AHIMA – http://montanahima.net/officers/
   - For AAPC, use the Find-a-chapter tool at https://www.aapc.com/localchapters/find-local-chapter.aspx
3. Lastly, there are many good online training programs available from other continuing education vendors, so we encourage you to look into additional options. Please note, however, that some vendors selling training services may only be offering an overview of ICD-10 that stops short of providing practical coding training. It's a good idea to research the parent company of vendors offering training to make sure they employ certified trainers and ask to see a training demonstration before committing to a purchase.

Are you ready?

BCBSMT has diligently worked to be prepared to meet mandated ICD-10 timelines and requirements. System and business process changes to accommodate transactions with ICD-10 codes have been implemented and we have successfully conducted testing with selected providers and clearinghouses. BCBSMT will begin accepting ICD-10 codes as of Sept. 21, 2015, for benefit preauthorization requests for services that will be rendered on or after Oct. 1, 2015. Valid ICD-10 codes must be included on claims submitted to BCBSMT for dates of service or inpatient discharge dates on or after Oct. 1, 2015. Claims without valid ICD-10 codes, as required, will not be accepted by BCBSMT. Additional information is available in the Standards and Requirements/ICD-10 section of our website at *bcbsmt.com/provider*.

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Helpful Resources

Below is a partial list of external websites for information on ICD-10:

- AAPC (formerly the American Academy of Professional Coders) – https://www.aapc.com/icd-10/
- American Health Information Management Association (AHIMA) – http://www.ahima.org/icd10
- American Hospital Association (AHA) – http://www.aha.org/advocacy-issues/icd-10.shtml
- Centers for Medicare & Medicaid Services (CMS) – https://www.cms.gov/Medicare/Coding/ICD10/
- Healthcare Information and Management Systems Society (HIMSS) – http://www.himss.org/
- Workgroup for Electronic Data Interchange (WEDI) – http://www.wedi.org/topics/icd-10/

Also refer to these BCBSMT resources:

- Visit the ICD-10 page in the Standard and Requirements section of our website at *bcbsmt.com.provider* for answers to frequently asked questions
- Watch the *Capsule News* and News and Updates on our Provider website
- **Questions?** Email us at *icd@bcbsmt.com*, or contact your Provider Network Representative

This Special Edition *Capsule News* is intended for the independent professional and institutional providers who are contracted with BCBSMT. We encourage you to share the content of this newsletter with your staff.

BLUE REVIEW
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This material is for educational purposes only and is not intended to be a definitive source for what codes should be used for submitting claims for any particular disease, treatment or service. Health care providers are instructed to submit claims using the most appropriate code based upon the medical record documentation and coding guidelines and reference materials.

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