Jackie King:

Good afternoon and hello everyone. Welcome to part two of our 2024 Coding and Documentation Webinar Series.

Jackie King:

Welcome, everyone. So my name is Jackie King and we're going to talk about ICD-11 readiness activities, the risk adjustment portion and why HCCs drive into that, and then social determinants of health coding again, so you're in the right place.

All right. My name again, Jackie King. These are my credentials. Lots of years, 35+ in healthcare, both as a clinician and as an administrator. So I have multiple coding certifications with our friends at AHIMA and AAPC, my Master's of Sciences in Health Informatics. So I'm a data geek, I love HIM, but I also love computers so that was the master's I chose to follow. Your slides may or may not show my new title, Vice President of Hospital Education, and ICD-11 Readiness Expert here at ArchProCoding. If you need to contact me, I don't disappear after I present, jking@archprocoding.com, you can find me. I'm going to do my best to peek at the Q&A box as we're moving, and our friend Ama is going to help us well and Elizabeth. So let's move forward to the next slide.

Just some disclaimers if you please. The contents of this program are copyrighted by ArchProCoding, which if we spell that out, it's the Association for Rural and Community Health Professional Coding, and aren't we glad we smushed that to ArchProCoding? It cannot be used, recreated, reproduced, or disseminated to any other party without our written consent. All rights are reserved. There are materials in this presentation that I am using from the ICD-11 Implementation and Transition Guide from the World Health Organization. If you use any of that material or wish to use that, go on out to the WHO and they will be happy to give you what you would need to know for licensure and sharing.

Okay, so agenda for today, overview of ICD-11. We'll talk about what even is it, and where we're at in the world, okay? And then we'll talk about doing a bit of a gap analysis or a needs assessment. So what are things we can do now? We're talking readiness. We're not about to train anybody on ICD-11, it's not happening in the United States. But what can we do to start thinking about getting ready? And gap analysis, needs assessment, creating your teams. We can certainly start doing that sort of thing now so we can be ready in the future. And then we'll flip over to where did HCC come from? What is it? And get into how we can capture that best with documentation and coding. And then social determinants of health, what is that? Again, how can we document that and capture that in the record? And then how are our coders going to be able to capture that and place it on the claims?

So starting with what exactly is ICD? So ICD is the International Classification of Diseases and Related Health Problems. It's the international standard for systematic recording, reporting, analysis and interpretation of data, morbidity and mortality data. So the 11th revision of this International Classification of Diseases is called ICD-11. And of course you already know that the US is currently using version ICD-10. So ICD-11 is more robust and it allows countries to count and identify their health issues by using a current and clinically relevant current and clinically relevant classification system.

We are 30 years. ICD-10 is 30 years old. Is that even? Yes, we've only been using it since 2015 in the United States, but it can result in data that can be used by governments to design good policies. Public health policies, measure the impact, allocate resources, and hopefully improve treatment and prevention and outcomes or actually use it for clinical reporting. So it's got more than disease diagnosis for statistical purposes. It allows us to code those signs and symptoms, causes of injury, rare diseases, medical devices, medicaments, anatomy, severity of scales, histopathology, lots of things, sports work. It links clinical terminology with statistics.

That's basically what ICD-11 does. And ICD-11 is more robust. So lots of uses. This infographic came from that technical guide. So clinical recording, the collection of those mortality morbidity statistics, epidemiology, research, case mix studies, quality and safety interventions, and planning for those. Primary care. Lots of things are built into this ICD-11.

So the global effective date globally for ICD-11 was January 1st of 2022. That came from the World Health Assembly at the 72nd meeting a couple years ago, 2019. So from that day forward, things at the WHO level will be reported using the 11 system classification. In 2022, there were 35 countries in the world using ICD-11 in some form. Wording from the World Health Organization: while countries are encouraged to follow their commitment documented with their approval of the ICD-11 at the World Health Assembly, there are no sanctions for late implementation and every country has its own special environments and systems in place. We're very special here in the United States. Our healthcare payer system, the disparate EHRs, the vendors, it's very unique. So obviously we are not fully prepared at this time to implement. So they're recognizing that everybody has their own set of criteria, hurdles to jump through before we're able to reach that transition.

So it is a revised classification. So again, not just diseases, it has a lot of things. There's a totally reformulated chapter structure and indexing system, so it is going to be totally different. Besides diseases, we've got disorders and injuries, those external causes. We already have this intent, but we've got it more robustly in ICD-11 and I already mentioned all of those and there are 120,000 clinical terms built in, but it can code millions more. It's very intuitive. The search feature is so different. There's thousands of new categories. There's updated classification schemes compared to the version of 10. You can use a very simple or very complex detail when you're selecting the level of coding, so it's giving you those options. So if you're thinking primary care, you might have a more simple level of coding where if you're talking disease, infectious disease, pandemic reporting, it's giving you that very complex clinical detail as well. And it is intended to supersede our 10th revision. And again, it's more than 30 years old and outdated. Going to check the Q&A. Okay, very good. I think those are more technical, so I'm going to move on.

Okay. Overview again, it's a digital format. It is completely digital, so it has tools and software to generate descriptions of health event information by codes. All electronic, all digital. It's been designed to integrate with local health information systems to integrate rather than provide that additional layer globally. In this country, I just am not sure how it's all going to work, whether TruCode, 3M, Optum are going to be able to somehow integrate it and let it sit on top. That's for them to figure out or how it's all going to work in this country. So we don't just have diagnoses in the United States. We have CPT codes, we have modifiers, there's a lot built medical necessities. So there's so much more built in that we, it's not as simple as it may seem at the global level. So how we're going to do that in this country is remains to be seen.

But the classification of 11 can be used on or offline. So if we're in places where we have low broadband or poor internet stability, it is actually able to be used offline as well. And the core functionality and support for this version are provided by an API, which is application programming interface, out of the box. There's no special licensure that you have to have or special programming.

I've got a few slides that'll show you some links to the package and how you can see what's out there and how your vendors, your EHRs, and your encoders, possibly your claims clearinghouse people are probably maybe taking a look at that right now. All right, it's digital or e-Health compatible, interoperable. Very easily, that's from me talking, interoperable with health IT systems. By integrating, it's making more use of data collection so it's going to maybe in the hope of the ICD world, not have multiple steps from transcription to paper, but letting things in the browser, the ICD-11 browser, generate a code and then hopefully allow it to be directly recorded back into your claim system.

Again, this is not necessarily going to be how it works in the United States, but that's the hope, and that's what's behind the purpose of switching to this new classification. The term, you don't have to memorize, there's too many codes to memorize. We shouldn't even really be memorizing at this point in life, but it's very intuitive and entering your term is going to help you lead yourself to that code. So we've got, I mentioned 3M, I'm not for against any product, but I've used a lot of them. And it's like a slope or you put your keyword in and it slips and it slips and you keep following a path. It's similar to that where the whole path opens for you and you can type your keyword and then it'll start opening a path for you. So it's similar, and that's because it's very intuitive.

So there are 26 chapters in ICD-11, and two supplementary sections of which 24 of those sections refer to health conditions similar to what were used to in ICD-10 before. The chapters and sections that were not in 10, that are not in 10, are Chapter 4, specific diseases of the immune system. Chapter 7 are sleep-wake disorders, 17 are conditions related to sexual health, and then 26 is that supplementary chapter on traditional medicine conditions. And then Chapter V or five, supplemental section four functioning assessment. And then Section X is extension codes.

So these are all of the chapters right there on your screen. I don't know how big that is for you on your screen, but there they all are. So you're going to recognize most of them are already our chapters. And then I mentioned on that previous slide, the chapters that aren't there that will be available.

Got a Q and A so I'm just. Joy, I will be bringing up the browser. I'm going to show it to you so it's exciting. I know I'm being weird and geeky, but it's pretty cool. There is no mandated time for implementation in the United States. We have some more I can talk to you about that when we get to it. So I will be able to answer that question as well.

All right, so they're alphanumeric. There's still alphanumeric, but the first character in all of the ICD-11 codes will always be, it may be a letter or a number, okay? So the entire code range for that chapter has the same character in the first position. Similar, right? Second character is always a letter. So the first one can be alpha or numeric. Second character is always a letter. And then there are hierarchical relations retained at that first four-character code level, very similar to what we've got now. Happy day, the letter O and the letter I have been omitted to prevent confusion with the number zero and one. We laughed as I was switching my glasses. Thank you glasses. I have glasses for the computer, and then when I need to get into the manual I have another set of glasses, so Os and Is can be very difficult and I'm glad they got rid of those.

This is just a quick snippet. So 01 are certain infectious or parasitic diseases. And then let's go, let's say we're looking for bacterial intestinal infections, cholera. So the subchapter is going to be gastroenteritis or colitis of an infectious origin. Bacterial intestinal infections, then we've got cholera. So 1, so the initial character is a number. A, always a letter on the second, and then 00 for your cholera. And again, I'll take you out to the web tool and it's got links in the slides to it.

Then we go over to, let's go to number 13, digestive diseases. Let's do acute appendicitis with localized peritonitis. Very common, right? You'll see it as it's starting to slide through the tabs, we're looking for appendicitis. Okay, DB10. And then we're going to say, okay, it's acute appendicitis and it has localized peritonitis instead of generalized. So this is where it's going. But you'll see as we get into the generalized or localized peritonitis, we've got the first four characters staying static. That hierarchy remains. And then you start, it's very similar to what we have now.

And then the advantages that I can bring to your attention now are that it is up-to-date. So medicine is continuously evolving, and applied sciences and new technologies are happening at an unprecedented rate. So the ICD needs to be able to reflect this revolution and capture clinical detail in the medical field accurately. So if you look at the first edition of ICD, it was in 1900, and there were 179 categories. Then

in 2016, the 10th revision, 12,000 categories. In 2022, the 11th revision had 17,000 categories. We're in there about right now. So that changed. It'll still be growing. So ICD-11 will still be growing as new technologies end and new clinical terms arise, it'll be able to manage this because it has an ontological structure.

So it's flexible, it's going to be able to use all of these codes in a variety of applications. And I mentioned earlier, improving the outcomes for patient's health, safety, population health, integrated care, even strategic planning and delivery of healthcare services related to these codes. And then again, the ontological structure. Ontological allows the system to code millions of clinical terms using combinations of all of the categories, and the entities and still keeping the integrity of meaningful data aggregation for the different uses that they're going to use the ICD 11 for.

So in computer science and information sciences, the word ontology encompasses a representation of formal naming and the definition of the categories, properties, and relations between the concepts, data, and entities that substantiate one, many, or all domains of discourse. So that's techie talk, but very more simply. And ontology is a way of showing the properties of a subject area and how they're related by defining a set of concepts and categories that represent the subject. So this ontological structure is living and breathing and searching and being intuitive and bringing all of the terms associated with what you're trying to locate to you in the screen. It's very amazing stuff. It's pretty exciting. Yes, I have some examples coming up. Okay, so the little black bar gets in the way sometimes. All right, let's move.

Improvement, so there are some new additions and improvements. There are quite a few actually. So there's a new set of primary care concepts where applications and settings where again, these simple diagnoses are made. There's a section on the documentation of patient safety events and it's been fully overhauled, systematically tested, and it allows for all necessary and detail and complies with the World Health Organization patient safety framework. Coding for Antimicrobial Resistance is not currently in our ICD-10, and it'll help us enable data documentation and analysis. And it's consistent with the World Health Organization Global Antimicrobial Resistance Surveillance System or the GLASS system. They've updated the HIV section with new subdivisions. They removed outdated detail, and then they've actually added some codes for differentiating HIV with malaria or HIV with tuberculosis.

There's this whole new Functioning Assessment supplementary section that allows monitoring of functional status through recording of codes for the before and after the intervention that permits what's called the calculation of a summary functioning score using the World Health Organization Disability Assessment Schedule or the Disability Survey for global world health. So it's really a cool before and after functional assessment section that wasn't there before. I would see a lot of maybe physical occupational therapy, maybe speech therapy using some of that, or other people that are providing medicinal or therapeutic treatments and a before and after codified, which is kind of cool.

Improvements, they've incorporated all rare diseases, but not all of them have a specific ICD code, but they all have what's called their own uniform resource identifier, their URI that allows those rare disease registries and researchers to access that detailed epidemiological data on conditions of interest such as COVID-19. The use of this facilitates linkage with other information interchange products and terminologies outside of the ICD. But there are other classifications out there in the world that this URI helps link.

Last, the supplementary chapter for traditional medicine. Traditional medicine's been going on for centuries in China, India, Japan, Korea, and has never been based on standard classification, nor has it been possible for us as health authorities to monitor or compare traditional medicine versus the non-traditional. This new chapter provides standardized descriptions for data capture, and allows country level monitoring through dual documentation alongside mainstream practice as well as international. So we'll be able to codify traditional medicine versus what's happening in, it doesn't feel like it's traditional,

but they're calling it traditional medicine when it's actually non-traditional in the United States, if that makes sense to you.

It's much easier for straightforward coding. It has that digital coding tool that can be embedded right into your IT system. Again, this is their version. I don't know how easy or hard it's going to be in our world because of the fact that we don't just use our encoder software for diagnosing or entering diagnoses, we have other things. We have national correct coding initiatives, we have medical necessity, we have CPT bundling, we have modifiers. So again, I don't know how well or how easy it's going to go, it's going to depend on our vendors in this country and where we end up, what classification and if we do any kind of customization in the United States. But the integration can help. If we can get this on board and working, it'll be great. That remains to be seen by the smart people at our EHR vendors and our other software companies. Remember that ontological core, it can be quickly expanded if new terms happen, if a new disease happens, if new treatments happen.

And then where there are paper-based bad situations like no internet, we can use a printed index or a paper-based version of this. There's a book out there too, so it is allowing that latitude for folks that may not have access to the internet because it's out there on the internet, but not everybody has access to the internet. Just checking through. Do you have any idea what the cost? Well, Carol, that is the golden question. No, I don't have any. It's free right now, but how are we going to get it into our system, that remains to be seen. So good question and okay, there we go. Just catching up with the questions, trying to stay on the slides in case it's related.

All right, a couple more things. The multiple applications are allowing it to expand for our growing public health data needs. Again, we've already talked about what I've got bulleted here. Research, case mix, or activity-based funding along with the other healthcare-related outcomes measures, that sort of thing. Previous versions have been able to do this, but they responded in what we call an ad hoc way. So they're limited, they're not very flexible. They only get updated once a year unless there's a pandemic.

So this ICD-11 is all out there to be able to identify this and get more timely, more relevant capture of morbidity data as it happens rather than waiting a whole entire year for updates. So again, your documentation that your providers are giving you can be broad or detailed, and we can actually report these codes on any level of specificity. We always code to the highest level of specificity, but it's not so huge that you can't use it in a primary care doctor's office. So that's what the improvement in my opinion is.

This is the Web-based Browser Tool, so I'm going to take you out to the tool and I'm going to bring it up. It's popping on my other screen, so as soon as it opens, I shall bring it over. So this browser tool just tells you the application programming interface, all the release notes, all the versions, any of the tools and how your vendors EHRs can install it locally. All of this on a Windows device, this is tech talk, but it's already out there.

This is an embedded browser version that they're putting out there free so that any EHR vendor, CPSI or Epic, MEDITECH, NextGen, any of these vendors are able to pull this in and integrate it into their system at no charge from the World Health Organization. Now that doesn't mean it's not going to have cost to that organization to be able to let their programmers figure out how they're going to make it happen inside of their system, but this is all API out of the box available now for them to be able to do it. So they can retrieve those concepts, search terms, search anatomy, anything that they could be looking for.

It has a context-sensitive help. There's an icon on the screen and I'll show you, you can click the icon and give them real life feedback what's going on. So if you do this, if you give them input through this icon that's taking back to the World Health Organization, they will take any of those proposed inputs, review it for consideration, and include it up to an annual basis if it's pertinent even sooner. They may even

push it out sooner, but I think it'll be annually. So you can continually help them improve the platform by talking back and forth. So this is just a picture of that browser page that I brought you up to.

And here is the coding tool. So we're going back out again to the internet and when we have this many people on, it's always a little.

PART 1 OF 4 ENDS [00:25:04]

Jackie King:

To the internet, and when we have this many people on, it's always a little ... It's going all right. All right, here's the tool. Look how simple that is. What you see on the slide is what you see.

So let's start typing in, "Diabetes." All right, as I'm typing, it's guessing the word being typed and it's giving you a lot. So it's giving you a word list and destination entities, and a way to sort. By matching score or by classification order. So just by typing in the word diabetes, I started getting a lot of codes. Some start with a five, some start with a nine, a B, you'll see all of that. So diabetes not otherwise specified is giving me 5A14. That's all I have.

But if I want to look at other information, the J that I clicked is related categories in the maternity chapter. So are they having diabetes in pregnancy? And the K was related chapters in the perinatal chapter. Is it neonatal diabetes? So they're giving you lots of extra things you can be looking at. Details of the code, so you can look at your documentation, and if it matches these terms, you've selected the right code. And again, further in, are we having a pregnant person? Is it some neonatal that's having this? So it just really goes down through the list. I'm just going to keep scrolling. That's the bottom of the list.

So then we can go to type one diabetes, and then we can hit details on that and it'll open up matching terms. Is it juvenile onset diabetes? So that opens all of this up for you. Preexisting type one diabetes in pregnancy coded elsewhere. Excluded, type two, obviously. Related categories. Are they pregnant? Are they having the perinatal period?

So this is all free. You can go out there right now and play around with it. It's all available right now. And it does search the content as we type. You saw that happen. And it gives you, dynamically, outputs. That word list, the matched entities, and a link to the browser. All of this is happening live. So this is just a picture, for whatever reason, if you didn't catch that on the browser, then I went out to ... This is just a screenshot of. It's very basic, but it has a lot of meat behind it.

All right, so the new version of exclude one, did you see not coded here? Down there? Let's see if I can go back there. But, "Not coded here, is going to be the new words that they're going to use, probably. "Not coded here," "Code elsewhere," that sort of thing. So there'll be a whole set when we get to the United States. There'll be a whole set of guidelines that the cooperating parties put together before we use D-11, in the United States. So I don't have full answers for that because no one has set the guidelines, no one has created an implementation date. So you're asking absolutely fantastic questions, and I'm going to talk about feedback to the National Committee on Vital Healthcare Statistics where you can watch and see that this may be moving along through the course of our government and our powers that be and our cooperating parties to get this thing moving. But that's good questions. Really good questions.

So in the 2023 release, we haven't had a 2024 yet. It's multilingual. All the tools in the application programming interfaces are available in all of these, Arabic, Chinese, English, French, Russian, Spanish and Turkish, and they are working on 23 more languages to make this API available. More new and improved coding support in the maintenance platform. I forgot to go out there and show you that little

button. Let me see if I can show you that little button. It's kind of cool. All right, let's see if I show you buttons on this screen or not. Let's type, "Diabetes," in here again. Where's my little feedback button? Well maybe I'm not seeing it. Well I thought it was in here, but I'm not seeing the little button. This is just giving you information on how to scroll.

Well, I'm not seeing the feedback button. Matching terms, seeing hierarchy. There's your exclusions. Okay, well we'll keep moving, but that button isn't showing up for me, so I'm not sure where it's hiding. But by the time we go to use it, we'll have it. Right?

All right, so updated mapping tables and a reference guide. That happened every year. They'll update those mapping tables. They added COVID-19 vaccines and SARA-COV-2 subtypes, as well as they used the new mpox synonym for monkeypox. We don't call it monkeypox, we call it mpox. And as of right now, there are 64 member states or countries in different stages of ICD-11, globally. So went from, what? 22 up to 64 in some form or level of using. Not the United States.

So what's going on right now? So there's a work group on timely and strategic action to inform ICD-11 policy. There are lots of folks out there using and talking about this at the NCVHS, National Committee on Vital Healthcare Statistics. You can keep yourself up to speed by hanging out here and looking at products, looking at the about, looking at if there's any kind of emails you can sign up for. But here are the people who are on this committee. Quite a few very smart people. And the next slide talks about your agency participation. So look at all of the agencies working at the federal level to make sure that this is done correctly. And I do have that on the next slide too. That is all your agencies. And again, if you want to click that link, that'll take you right back to that website. CDC, CMS, all of these people are out there. So just the National Committee for Healthcare Statistics, the Library of Medicine, the Institute of Health, the ONC, we're all out there in the world trying to make sure we're doing this correctly.

And then most recently there was a request for information. There have been two. So the first RFI went out, and it usually goes out through the State Offices of Rural Health, and it was received, July 27th was the cutoff date. And I've got a link to the responses. It's super interesting to read. So read this. So those questions that are popping in, some of them are going to be addressed here saying ... These are the people that responded. So 3M, American Clinical Lab, AHIP, AMA, AOA, certain universities, certain companies were doing it. This is all the different people. Kaiser Permanente, the actual Minnesota Department of Public Health answered, Texas Department of Agriculture.

So all of these respondents, there was 19 of them. This is their answers. This is what they gave us. So it's a 95-page PDF. Very good read. They're out there saying, "Hey, we're worried about this, we're worried about that." They sent a second one out at the end of '23 and it was due back January 12th of this year. So I know several State Offices of Rural Health. I helped with Illinois getting theirs in. I know Indiana did it, because I'm working with them. Asked the stakeholders and answered the questions, and they should be putting this together. It's not even been a month yet. So they'll be putting this together and another RFI response policy link should come out there. So I'm excited to see that. We have been given a chance to give our voice and say what we're concerned about and it's really great read, especially if you're worried. Don't get too worried.

So another thing I want to tell you is in the world of federal aid, or grants, there is a SHIP grant, Small Hospital Improvement Project grant. And the language of the SHIP grant, which runs a five-year grant period, it started June of '23 and goes through 2028. In this five-year grant cycle period, there is specific language for ICD-11 readiness and implementation activities, and there is funding out there to have you start being ready. So the HRSA is who funds this grant, and they have received feedback from prior transition, 2015, of stakeholder issues that we ran into that we shared with them. Education, backlogs, so many things. So they're trying to be proactive and they're trying to get out there and they're saying,

"Here is some grant money available to the small hospital improvement project grantees for helping you get ready." All right, so that's kind of what we're transitioning to for the next couple of slides.

So I've put together, as my 35 years of healthcare and as I transitioned from nine to 10, some ideas. So the first thing I would suggest for you to do as an organization, as a clinic, is do a gap analysis. A needs assessment. What is a gap analysis? A gap analysis is going to be an examination and an assessment of your performance and your processes for the purpose of identifying the difference between what your current state of operation is and where you want to be. It helps clarify the difference between reality and the ideal for your organization. So if there's an area where you're experiencing barriers or inefficiencies, you can better focus your resources on those and then get them cleaned up and get them improved. So if your organization isn't on track to meet your goals, a gap analysis can help you uncover practices, processes that are maybe preventing you from achieving your goals.

So such an analysis, you can do a gap analysis within just a specific department, a whole hospital, a whole clinic, or for just a single process. Maybe you do a gap analysis on point of service collections when you're checking patients into the clinic. That's what you can use this type of tool for. It's not new. It's been used in the for-profit business world for years to help explain deficits between the actual performance and what they budgeted and what really happened. And more and more healthcare organizations are buying into this process because they can see real results and successful improvements from performing them. So my recommendation, this is just me talking, do a gap analysis. It will examine and assess, "Where are we now," and, "Where do we want to be?" So when you're thinking of things that touch ICD, where are we having some barriers, some roadblocks, and what can we do to close that gap? We can identify gaps from top to bottom, and I will go through some slides of where my experience people are touching ICD-10 right now, and something you could think about for performing a gap analysis on those.

So the first step, what's going on? Identify the state of current process. Look at your processes, look at your statuses. Maybe make a red, yellow, and green. Green is everything's working great. Yellow could use a little work. Red, this is absolutely not working. We need to look at this.

So once we look at the current state, we need to define what is our desired state? Where do we want to be? We want green, right? We want everything running smoothly. We want no backlogs, we want no slowdowns. We want to be efficient, we want everybody to be happy. And once we've determined those gaps, we've figured out the gaps, we are going to look at the nature of the gaps. So in healthcare, are they related to communication between the doctor and the coder, between the coder and the biller, between the front desk and ... There's lots of places that communication in and of itself can be a gap.

How about processes, workflows, software, training? There's so many things in healthcare that we could have gaps that we don't realize. So be sure that when you do this gap analysis, you include everyone involved in the process. Ask everybody the same question and include all their answers in the process. Everybody at all levels, so you can create a plan that targets the processes for improvement. Those are the people whose boots are on the ground that are working, struggling, feeling the pain that can share with you. And some of these folks, depending on what position they're in, if they're at the front desk, they're probably a nice little extrovert. But some of those coders and billers can be very introverted, and not generally going to outspoken come to you with a problem. This is a chance for them to be able to tell you maybe they have a better idea, but they're so quiet and shy, they just feel like they're better to put their head down and suffer rather than help with the solution. So this is where we want to include everybody. It's just really beneficial.

So then you figured this out. And you maybe could do focus groups, do in-person, do focus groups, do discussion with your different clinicians, or coders, or billers, or registration staff. And then what are people, the leaders of the departments and the workers noticing day-to-day surrounding this issue? Just

review your documentation around your policies and your procedures. That could be a contributing factor. You just really are going to need to dig deep to find the answers, but that's the nature of the gap.

And then we're going to create a plan for improvement based off what you find. Everybody's going to have a different gap. Or maybe you're perfect and you don't have any, and hallelujah to you. But you've discovered some gaps. Now we're going to figure out ... We've asked, we've done facilitated process improvement team, or we've just got that stakeholder feedback down to the worker level, from the manager, to the coder, to the biller, to the registration clerk, now we're going to figure out the proper course of action to close it. So again, those people who are working are going to be your best source of information to work through the processes and clean them up. Those are your people. Rely on your people.

And then the last thing you do is once you put these awesome plans in place, be sure you follow up on these improvements. You may have staffing changes, the fact that this implementation date is hanging out there in the next five years, we think ... The language in the HRSA grant says mid-grant cycle. So that would be what? 2026? 2027? That's the best thing I can give you is that they are requesting information. There are wheels turning. We just don't know how fast they're going to happen. So once you have them, follow up. We don't want to slip back in old habits and we don't want to have new processes that we worked so hard to create fall through the cracks. Okay. All right, I'm going to check the box.

Will it crosswalk to ICD-10? Good question. Not sure. When we transitioned, AAPC required credentials holder to take a test. So AAPC and AHIMA are friend. At the national level, I'm sure are on top of putting together a certification. I work with different states. Me, I'm not about to put together a certification on ICD-11. I'm going to take the same test you guys do when the time comes. I'm sure that these big organizations will put together a certification process when the time gets closer with a lot of stakeholder feedback.

No, I have no ... No. Carol, I do not think CPT or HCPCS will change in the United States. They're just tied too much to financial feedback. They're just tied too much to financial.

Any suggestions on how to begin a gap analysis? Everyone's busy, staff turnover continues to be a problem. I think most of us know our issues, but where to begin is the hardest part. So let me take you to the next slide. Really good segue. Thank you for that. All right. Look at your existing policies. Look at your internal processes that have to do with ICD. With coding. What policies might be impacted if and when we transition? I don't think it's an if. I think it's a when. And then don't wait till the last minute. So now we don't really have a team, but I'm going to talk about that. Even with no definitive implementation date, we can be thinking about internal processes and what might be impacted. Update those sooner rather than later. Or at least identify, these are the 18 policies in our master policy book that pertain to ICD. You've at least got them identified. Somebody's had eyes on the prize, and you know.

Another thing to do as it gets a little closer, clean up your backlogs. So make sure you take that time to get the coding backlogs or claims issues cleaned up before the implementation happens, because it's going to help them focus on their new system and not be hanging out in the old system and crisscrossing for too long. So clean up your backlogs. Coding, of course, everything you can get coded right up until the last minute is great, until you flip the switch. Billing, get those old claims worked. If you have a legacy system, you want to get as much out of there. You may need to start looking, when the time comes to secure additional help to resolve those past claims to get the documentation coded and sent over for billing and resolve those before the implementation date. Because if you wait till the last minute to try to contract with an outside resource, you may not be able to find any you may be in a bind and be out of time because the pool of labor may have dissipated because everybody else has already contracted.

So backlogs are always an issue. We don't like to see our AR days go up or anything, but that's something you can think ahead about. How are you going to do it? Do you have a partner that you could start looking at? So if the time comes and you need extra coding or billing support, you can have them as a partner and as a friend. Prepare for financial disruption. It's going to happen. Transitioning, I think, from 10 to 11 won't be as intense. But revenue cycle delays are possible and probable. Everything will slow down. When you're trying to learn something new, you go slower. Coders are going to go slower, providers are going to go a little slower, just depending on what your workflow is in your clinic. If your provider's selecting their own codes and having to search in the system, everything looks different. I think it might be easier with this new technology, but we just don't know. So give them some grace and prepare yourself, and have contingency plans for the fact that your error days are going to go up and your productivity is definitely going to slow down.

When we went from nine to 10, in my experience, within three to six months, the bulk of people were able to come back to their pre-transition levels. But some people took up to a year to get their productivity back up. So maybe they were still cleaning backlogs up. Just imagine. And if you're a coder, you can imagine your brain having to switch from one to the other. And I lived through it. I know. So be aware for the potential and the probability of some financial disruption. Make your coder and provider education a priority.

And because of the delays in implementing ICD-10, a lot of HIM departments put off the coder training, and then it caused our coders to be unprepared when the time came. So then we were struggling. So timing is tricky, because most of us don't want to start too early. If you don't use it, you lose it. We don't want to combine those two sets of codes in our brains. But getting an early start in education for your coders to be prepared, we need to familiarize ourself and just at least get out there and play around with the structure. So lots of good questions in the chat box. If you play around in there, you may be able to answer those for you. There's a whole section by section education thing in there that you can take. There's no certification from the World Health Organization, and of course this is our country, so again, I think AEPC and AHIMA will put something together.

So when we're using this and we're thinking it through, many of the successful organizations dual coded for six months to a year when the time got closer, so that we could say, "Okay, here's the ICD-11, here's the ICD 10." And then if we were looking at the two sets of codes, we could say to the doctor, "This gives us much more level of specificity. If you could give me one or two more words, I can code this better when we get to 11." Even at 10, we've all got a long way we can go for higher level specificity in our documentation.

So CDI, or provider documentation improvement, that's always happening, even now. So we always want to be able to feedback. Our coders need to feedback to our providers if we're auditing their claims and their documentation to make sure it matches or if things are missing. Always a very important process.

UDS plus changes. I don't know what UDS plus is. I'm so sorry.

Okay, so next slide. Let's talk about creating your teams. You could be creating your team right now in your clinics. So two things that could be happening right now. Strategic planning. So you can have a strategic planning team and create an ICD-11 team, just meeting very infrequently. Obviously your administrator. Someone from administration needs to be part of this. Bring in your coding manager, and your billing manager, and your registration or patient access person, and depending on where you're at, this could be the same person. And then get a medical staff representative on there. Get your physician champion. And they don't have to meet a lot, but let them know it's out there, let them know there's been two RFIs sent out nationally. This system is out there, we're starting to have conversations, we need to create a team.

And then once the implementation date comes closer, now we're going to be able to start a project management team. We're going to want an administrative lead on our team so that what we're doing at that level can go back to the admin team. We do want a project manager. Very important. Give that project manager the latitude and the time that it's going to take for that person to do this job. A working project manager, if they're not allowed any extra time, isn't going to be a whole lot of help to anyone and they're going to get frustrated. So when the time comes, please allow that project manager latitude in their daily activities, or weekly, so that they've got time to work on this project. You're going to want to bring in subject matter experts, depending on where you're at in the process, and maybe not at every single meeting, but obviously coders, billers, IT, informatics people are going to come in, depending ... Your ancillary department managers. Bring your lab and your imaging people pre-cert. So they won't always be there at every meeting, but they definitely will need to be included in the process.

And your CDI people. So depending on whether you're part of a health system, your freestanding, you may or may not have a whole formal CDI program. A lot of times that's on the hospital side for bigger PPS hospitals, but it's great to have clinical documentation improvement involved, and many, many, many times in a clinic, it is your coder. That is your CDI person. That person is reading the documentation and identifying gaps and opportunities for better improved documentation so that we can capture our codes better and report our ENM levels better. So CDI, many times in a clinic setting is your coders.

And then of course, nursing and clinical support staff will be needing to come in here, because they're going to be the folks that are doing some, possibly, documentation, putting in things in CPOE, which is Computerized Provider Order Entry. Many times, the nurses or support staff will load the orders and then it'll go over to the physician or provider to sign off on. We want those clean and correct the first time, so they can go on over and the doctor can continue to do their business and just sign off on the orders.

So create a plan. When you've created your team, how often are you going to meet and who's going to come to the meetings? At first, of course, you're probably not going to meet that often, but maybe you're going to meet and start a gap analysis, and that might be the first thing to start. And then create your goals and measures based off what you may or may not have found in your processes now. The people that are currently-

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Jackie King:

May or may not have found in your processes. Now, the people that are currently using it, I guess I didn't list it out, but I have talked about it, pre-cert. So whoever's doing pre-certs for testing, registration, billing coding, physicians, ancillary staff and IT, everybody that's touching ICD-10 now would be who I would talk to for your gap analysis. And I do have this whole thing on the side. I've got one created that I've worked with Indiana for... I just took all of the various departments and thought about how they touch it now and how could we do better or identify if there was a problem.

So I want to use this next bullet for outside training needs. So here we are talking about it right now, but how are you going to identify outside training needs or outside training helpers, educational people? So you've got NAC who is phenomenal and they're going to be on top of this for you, but at your level, maybe there's something to identify in your gap analysis.

How are you going to get some help on that? Just start looking around and getting... Word of mouth is great and see what you've got out there and then see if there's grant funds available. I mentioned that

the SHIP funds have been made available. I live in Illinois, and when I went through from nine to 10, I was actually contacted by a local Incumbent Worker Grant Program from the state of Illinois. They said, "Hey, do you have any incumbent coders that you need to help train so that you can retain your workforce?" "Well, yes, all of us." So what they did was I had six coders and myself and they paid for my books, all of our books and the training.

So we purchased it from AAPC. We sat at lunch a couple of times in one week and spent two hours of our lunch break. I made sure I got pizza or sandwiches for each day and we spent the time together and we got certified and it didn't cost us anything but a couple lunches and a little maybe backlog for that week for the coding. But there are grant funds out there. Don't be afraid to ask. Don't be afraid to ask because there could be something out there in your area that would pay for this for you or help you. And then that's the end of that. Let me just check your boxes.

So hrsa.gov is the Health Resources Services Administration, your State Office of Rural Health, absolutely. You probably have a state office of Community Health Centers Association. Those are just the top. Your townships, your local governments might have something also. Just some ideas to get you started. And if anybody from NAC could possibly talk about that offline and help your constituents maybe with some ideas for grants, that would be awesome, okay.

So we're flipping over to HCC Risk Adjustment and Social Determinants of Health Coding. We're going to talk about documentation and coding and how we're going to get it right the first time. So where did HCC come from? Hierarchical Condition Category. Wow. HCC. So this came from the traditional fee-for-service payment model. It's been used all the way back since... The fee-for-service came back when, what, 1930s we had initial health insurance plans starting in the United States. When you're talking fee-for-service, you just do the service and you get paid, do the service, and you get paid.

Well, guess what we're doing? We're going broke in this country. So they're paying a lot of attention to spending now versus outcomes and quality of care. And we're using this compared to healthcare spendings in other nations. So it's very important that our country has started looking at other focuses. So value-based reimbursement, not just fee-for-service. How are our patients doing? How are they faring? Back in the 1970s, they started demonstration projects with Medicare that started with HMOs, Medicare HMOs to provide care for beneficiaries, Medicare people, in exchange for prospective payments. So they ponied up the dough, you spent it wisely. If you had good outcomes, you made some money. If you didn't, your lost, right?

It was a risk. It was a risk plan. So it's still going on. In 1985, they changed it from demonstration to a regular part of the Medicare program called Medicare Part C. And in 1997, the Balanced Budget Act did change it for a little while to Medicare Plus choice, if you remember. But the MMA, Medicare Prescription Drug Improvement in Modernization Act of 2003 changed it back to Medicare Advantage, and that's where we're at. So Medicare is one of the largest health insurance programs in the world, in the world. And about a third, actually, we're about to about a half, I think I just read a publication from Medicare on who's enrolled in Medicare Advantage versus Medicare, and it's about 50% of eligible beneficiaries have selected Medicare Advantage Plan, half of the beneficiaries eligible. So we need to be aware of this because Medicare advantages are like HMOs, they're their value based. That's how they're contracted. Okay.

So we need to be aware of this and understand this so that we can be prepared as clinics and as recipients of the payments and be ready. So risk adjustment. The risk adjustment model uses these HCCs, their ICD-10 codes to assess the disease burden of its entities, of its enrollees, using what's called RAF scoring. So RAF scoring is a Risk Adjustment Factor score. So a RAF score is a predictive model so they can help estimate how much it's going to cost to take care of your patients and give you the money upfront basically, as a benchmark goal. The primary driver is going to be the ICD-10 codes that map to

an HCC. Then there's also demographics. So male, female, where in the country they're located, and then program enrollment. Are they end-stage renal disease? Are they dual eligible, meaning they have Medicare primary, Medicaid secondary?

Do they live in a nursing home? Are they living at home? Do they live in an assisted living facility? So that demographic is part of it, but the main driver of your RAF score are HCCs. What's going on with the patient? So why should we think about adding, thinking about HCC coding, and we're already so full, our plate is full. Well, there's a couple of big reasons. One is good patient care. So for example, if you are looking at your scores, a higher RAF score can trigger a referral to a patient for CCM or case management in an accountable care organization. And the second is money. I mean, your practice's RAF score will likely affect your compensation now or in the future when you're trying to make arrangements with Medicare Advantage plans for reimbursement contracts. I realize that many of us are cost-based, but these Medicare Advantage plans don't always like to give us our all-inclusive rate or our rate.

And then there are many commercial payers that are jumping on board with this. So we need to be in a good spot and have everything reflected properly so that when the time comes that they may flip us over to a value-based contract, we're on the front end of this and we're aware. So when you're looking at risk adjustment, again, they quantify your patient's wellness or not into a score. They calculate the score. They consider CMS as an average person is a 1.0. So if you wanted to know your RAF score, if you had less than a 1.0 average RAF score in your patient population, you probably have either a really healthy beneficiary group without any chronic conditions, or you've got some beneficiaries that absolutely have chronic conditions that weren't reported on a claim. And those chronic conditions are reported with ICD-10 codes which are mapped over to HCCs.

Anything greater than one would signify that you've got multiple chronic conditions on your patients and that's been reported properly. There aren't that many that are completely ambulatory and have no problems. We love those people and we're happy for them, but that's not the norm. And remember, when you're thinking of Medicare beneficiaries, remember that Medicare, yes, you age into it at 65 or older if you or your spouse paid into the program during their working lives. But we have lots of people under 65 that have certain disabilities that are Medicare beneficiaries. And again, your end-stage renal disease. So it's not just for 65 and older, and a person who has a disability forever that's on Medicare is going to potentially be a very high cost. Something happened that deemed them unable to work. So a long-term cost as well. So keep that in mind. It's not just for 65 and older.

This is just an example of some RAP scores. So I have Jane and John Smith. John is 85, male, Jane is 65, female. So we're looking through, so the age gender, just because John is older and a male, he's double the risk. They both have arrhythmias. So that is an exact same score. John has cirrhosis of the liver. Jane is morbidly obese, and Jane has diabetes with chronic complications. So let's look at their RAP scores. Jane's is 1.14 and the reason why she wasn't up over John is because she was 20 years younger and female. But that gives just an example of a RAP score, just a generic example. We have to remember that sicker patients like Jane are going to need some more time and effort in the care delivery process, and this translates hopefully into an increased pool of funds from your value-based contract so that you can take care of Jane properly, because she's got a lot of stuff going on. So that's something to keep in mind with that.

So again, an HCC hierarchical condition category, groups of similar ICD-10 CM diagnoses that consume similar resources. They're known to be a disease burden. Not every diagnosis code runs over to an HCC. I have a slide that shows you how many there are for 2024. They're like a DRG. If you've ever worked in a TPS hospital, those are diagnosis related groupings. They take groups of ICD-10 diagnosis codes and weight them so they can prepare. They're getting reimbursed based off that. But when we're doing with

risk assessment is preparing to pony up enough money to take care of these patients based off their chronic conditions. They're generally chronic, lifetime conditions, and then they're also listed in hierarchy.

So diabetes with no complications is going to be a lower than someone who's got complications. So that's all driven by your codes. Developed again to account for and express your major costs and factors of your Medicare enrollee, utilized to communicate the expected and current costs down to a patient level. We can use these to identify and close care gaps for our providers and our patients. So we can run lists out of our reporting system to see if we've got patients who haven't been seen in a year, and that's a care gap, especially if they've got chronic conditions and they do update these annually.

There's a link to the Medicare Managed Care manual. I'm not going to open it because it's not real exciting, but I like to give you a link so you can see all of the information that I talked about in a much more detailed way. So what determines an HCC? It is a prospective model. So anything from this year, ICD-10 codes going on in 2024 are going to be used to predict spend for 2025. So right now, at the beginning of this year, we have 2023 codes that went out on our claims for our patient population, giving us a benchmark by which to take care of all of our patients for this year. So hopefully we got them on the claim last year and they're giving us the right amount of money. The sources that it comes from, only sources from face-to-face visits.

So basically E&M visits. So doctors, anybody who's licensed to practice medicine in your outpatient settings. So your clinics, outpatient and inpatient professional fees and emergency departments, it's face to face, okay. And then we map those. Only diagnoses that map to an ICD-10 are going to be used in risk calculation. Obviously a sore throat is not going to. Pharyngitis does not map over. Again those demographic variables. Are they aged? Are they dual eligible? Did they go to 65 and over or did they become disabled under 65? Male female? And where do they live? Nursing home, home, assisted living? And then disease hierarchy. One, HCC, the most severe is assigned because many of our patients have multiple chronic conditions, but the worst and most severe is going to be used to prospectively decide how much money your contract is going to pay you and put up in front to let you get good care for that patient. And there are outcomes measures as well in an ACO. It's not just less money, it's good care, okay.

I see something popped in the chat. Good question, Joy. The RAF score is not listed on a claim. It would be at the contract level, so if you're in a Medicare Shared Savings, that RAF score is built within their contract between you and your payer. So HCC [inaudible 01:04:12]? Okay, HCC is not... A good question. You guys are doing great. It is not strictly for Medicare, but you are a Medicare based group of people. So I'm talking about that with... No, in Illinois, I work with an accountable care organization that has 26 hospitals with multiple FQHCs, RHCs and they have a Medicare Shared Savings and they have one with Blue Cross and Blue Shield of Illinois. There are commercial payers out there doing value-based contracts, absolutely. So good question. Medicare Advantage plans are going to be pushing those too. Okay. So it isn't going to go away. It is going to just expand.

The winner of a value-based contract is the patient. Is you're taking good care of them, you're making sure that someone's controlling who they're going to see. You have a gatekeeper, primary care doctor is your gatekeeper. You are the gatekeeper. So you, yes, you may need them to go to a cardiologist, but then you're going to make sure they come back and you're going to make sure you get your information back. And now, okay, nope, we need a gastroenterologist. Okay, come back to me, now I'm going to send you to your GI doc. I'm going to have you come back. That controls the patient's outcomes. You're communicating with them, you're controlling spend so that they're not duplicating services because you've got this primary care practice relationship. You're the gatekeeper, and then you let them go and

do their thing where they need to, but they come back to you. It really does work. Patient feels value. You've got a good relationship with your provider.

You will see control of spend just by that and better outcomes. So that's my experience. Checking on time, we're doing good. So helpful hints that I can give you for these. Remember only face-to-face visits, doctor office, in or outpatient professional fees, no hospice, no home, no freestanding surgical centers and your providers are anybody who's a licensed provider with that payer and in Medicare, you know who those people are. So no DME, no lab, no radiology, none of that because those are not necessarily definitive diagnosis at that time. The definitive diagnosis is coming from a physician or a qualified healthcare practitioner. That's the diagnosis we're going to use. And then every year it has to be on a claim at least once per calendar year. So January 1st to December 31st, once in this calendar year, if they have got a chronic condition, it needs to be reported again on the claim in order to be calculated to give you financial information.

Medicare knows if you don't see them and they know if that doesn't get put on the claim, because I would get reports. Out of 40,000 patients, 3,500 were sitting there at any given quarter with a historical HCC that hadn't been recorded yet on a claim. So they know, they want that patient in front of you. They want you taking care of them. Okay. Problems we can see with this is patients that have HCC's or chronic conditions not scheduled. They're not coming in. We really saw a lot of this during Covid when they were fearful to come in and see you. But now that's behind us, sort of. It's under control. Maybe you don't have tools to identify patients, but I can tell you, you all be able to run a report of traditional Medicare patients and when they were last seen in your clinic. During the visit, maybe the doctor isn't capturing all the diagnoses or maybe the coder isn't placing it on the claim.

So we need to work together and make sure that everybody on the team understands how important it is to capture these. Got a couple of slides to talk about that coming up. This is just a quick matching slide. For 2024, there's about 11,680 ICD-10 codes that map over to about 189 HCCs. And just the number of the HCC has nothing to do with the weight. The weight is all behind the scenes. You don't have to know all of this. Just know that the doctor needs to document everything and you need to catch it on the claim as a coder. That's what I want you to bring out of this, but I'm trying to give you some input of where the heck this is coming from so you know what we're talking about. This is an old payment methodology perspective, okay. So look at the 2016 RAF score for this patient versus 2017, same patient.

Their demographic score didn't change much. They got a year older, right? Diabetes with retinopathy was reported out on both claims in both years. Morbid obesity too. But this person had RA, dilated cardiomyopathy and COPD, none of which were addressed and reported on the claim. So either they were addressed and the coder didn't capture it or the doctor didn't capture it. In any case, they didn't get counted into their RAF score. So their RAF score was 2.7 for 2016, and it was only 1.038 because someone didn't capture those chronic conditions. None of that goes away. Very big weight and it could cost per member per month $10,000 to an organization by missing those ICD codes. They don't generally go away, right?

Okay. Can you explain [inaudible 01:09:19] hc? So I think I'm explaining how it would affect you. The condition, if it's one condition per HCC, not one condition total. RAF... I'm not sure if I'm answering that or not. So if you're in a value-based contract, at this point that's how it's going to affect you in an FQHC. And more and more are starting to be part of this. If you're in an ACO, it affects you. So if you're in an ACO, this talk needs to come right to you and you need to hear it. That is the biggest thing right now is an accountable care organization. Some value-based contract with a payer, if that helps. I'm not sure I'm being very helpful with that, but maybe as I keep talking, it'll help. All right, so they go out on a claim, these ICD-10 codes go out on a claim.

How are we going to get them on the claim? Well, if you're using a 1,500 for your commercial payers, you can get up to 12 ICD-10 codes on a claim for your non-Medicare. Older software, a lot of places may have older software that will alone we allow four. You need to update that. That's outdated. This should allow 12 at least on a 1,500. Now when you get up to a 1,450 or a UB, it allows up to 25 and our FQHC bills are on UB. So you've got room for 25 ICD-10 codes. So the first thing is, "Well, we can't get all those on a claim." Well, you can get 25, so that's pretty good. So the next thing to talk about is the guidelines. So I'm a coder now and I'm going, "How am I supposed to get this on the claim?" All right, I'm going to talk to you now.

The guidelines state, for diagnostic coding and reporting guidelines for outpatient services, chronic diseases treated on an ongoing basis may be coded in reported as many times as the patient receives treatment and care for those conditions. And letter J, code all documented conditions that co-exist at the time of the encounter and require or affect patient care, treatment or management. It's right in the guidelines telling you to code this. So now we've got our green light to code it, but we have to remember, we need a doctor to document it. So just a summary, that HCC and risk adjustment, those codes have to be submitted at least once in a calendar year to maintain the financial pony up the dough to give you the money to take care of the patients and potentially share savings with your payer. That baseline is used to predict future costs.

Your budget, you're helping your insurance company budget how much it's going to cost to take care of that patient population. So missed opportunities or misdiagnoses that weren't coded could forecast an incorrect baseline and not give you enough money to take care of them. So failing to do that could reduce your reimbursement if you're in a value-based payment method. That's where it would affect you mainly at this point, if you are in an ACO or we are trying to get you squared away and have some thought process. Also, it's just good care. When we read the documentation, we as coders, we're going to tell this patient's story. We're taking the words, we're codifying them, we're telling the payer, we're telling population health, we're telling even public health the story every time of this patient. It's our obligation to read everything and report what happened today and tell that patient story to the highest level of specificity. That's our job.

So when we're looking for documentation issues from the doctors, we may not see them document or we may see them not code to the highest level of specificity. We need to be precise and detailed when we're talking about what's going on with this patient. Is it a drug-dependent patient or are they abusing drugs? That's different. Is the cancer active or in remission? Is it an acute or chronic condition? What's the stage of the chronic kidney disease? If they have hemiplegia from a CBA, was it their dominant or their non-dominant side? These are so important to the cost prediction to take care of this patient. Those are one or two more words that will help us code to the highest level of specificity. We may see chronic or coexisting conditions not addressed appropriately, completely left out. We can see their problem list. We can see they've got chronic conditions.

We didn't talk about them today, so that's something. We see history of when we're documenting current stable chronic conditions. That's a habit. When you're documenting history of present illness, that is the patient's own words what's going on today? What led you to come see me today? But they don't have a history of COPD. They have COPD. They don't have a history of diabetes mellitus with peripheral vascular complications. They have it. So that's where we need to be sure we're talking to our docs and making sure they're giving us the right words. So here is the meat and if you're a coder, you've seen this. Meat documentation. If they're hitting the meat in their documentation, you can grab that ICD-10 code. So did they monitor sign symptoms or disease progression? That's your M. E is free evaluate. Did they read test results or evaluate the response to a therapeutic treatment medications.

Assess or address. Did we order tests? Did we discuss with the patient? Did we review outside records? Did we provide counseling to the patient? And then T for treat. Did we order medications or other therapies or other modalities? So what we need to see is this meat. You don't necessarily have to have all four letters, but this is a really good guideline that you can work with your providers on to make sure that they're documenting the top to the bottom of the patient at every visit. So Medicare will allow you to code from a problem list if you can see the E and the T.

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Jackie King:

From a problem list. If you can see the E and the T evaluation and treatment for each condition as it relates to a diagnosis code they're trying to place on a claim. So we've got to see if you tell me they have COPD, maybe they're here for an ankle sprain, but they do have COPD and if you tell me they have COPD and it's stable and they're using an inhaler, I can code COPD as a coder. And maybe you're going to offer some treatment, some therapeutic treatment. Maybe you're going to offer a medication that may not work well with somebody who has COPD or maybe they have chronic kidney disease and you can't give them something that is coming out through the kidneys. So there's things that you are thinking doctors, write it down so I can put it on the claim so I know you're thinking it. How can I get it written down so I can get it on the claim.

Now, past medical history, it just depends on your EHR to whether you can do this. Everybody's are different. So you can use past medical history also if it's pertinent. But you need to see this type of supported documentation. CHF, symptoms well-controlled with Lasix. Continue current meds. You told me what they had. You told me the status of it and how you're going to treat it. I got it. Major depression. Patient continues to feel down despite Zoloft 50. We're going to increase it to a 100 and monitor even hypertension, stable on meds. Continue current dosage. I don't even need to know what kind of medication they're on because you gave me the status, the diagnosis, the status and what you're going to do about it. So those are M.E.A.T. That's M.E.A.T. right there. All right, I'm going see if I got some.

Is there a best practice? I'm going to have to wait on this one. I think. Is there a best practice advice regarding whether the codes that a coder adds, provider documented but maybe didn't select the code? Yes, need to be communicated back to the provider. So the medical record visit diagnosis can be updated to match what goes out on the claim or is it okay to manage. So your EHR, the diagnosis that the provider's giving you may not be a highest level of specificity, but you can see in the body and in the M.E.A.T. that it's there. You are a coder. You can code that. The record is the source of truth. If it's in the record and it hits the M.E.A.T. criteria, you don't have to go back to the doctor unless it's flagrant. If it's right, it's supposed to be left, you've got to stop right there.

But if it's just a little bit more information in the pick list of ICD-10 codes, it's not a real easy tool to search. So a lot of times they're going to not get down maybe as far as they need to in that pick list to find that higher level. It's our job as a coder to read the documentation. If the M.E.A.T. documentation supports it, it's our job to get the right ICD code on that claim. Same with an E&M. For doing an E&M, we use medical decision-making or time. If that medical decision-making is more than the time, we're going to use medical decision-making not time. We're giving the doctor the best bang for the buck and the record is the source of truth and every payer can feel free to look at the record because that's how we're coding, the record. Hopefully that helps you.

So I gave you the example of problem list. If evaluation and treatment was shown, M.E.A.T. can be anywhere in the chart. Absolutely. And I think I have that coming up. Pertinent mean that past medical

history still needs to be documented as addressed. Exactly. If it just has past medical history and no M.E.A.T., you can't use it. It's there. But you can start querying the doctor and having those conversations. Hey, I noticed you're missing and you're skimming over some of these chronic conditions that may still be active. That's just a patient or a provider documentation. Yes. Evaluation and treatment in the note to be able to report the code. You guys are right on top of this. Good job.

All right, documentation best practices. So this is probably going to help you as coders asking these very intelligent questions. What are some best practices? Any causal relationship should be linked for complication or manifestations of the disease. Is it stage three chronic kidney disease because of hypertension? Is it diabetic chronic kidney disease? These are the types of things that we need to work with our doctors so that we can get that highest level. They could say they have diabetes and there are rules with and code also. Sometimes we have to supersede it. They may have hypertension and congestive heart failure and have two different codes like I-10 and your CHF code. You have to bill an I-11.0. So there are coding rules that we know as coders that we are going to have to override what got selected in the pick list. And it's okay because the rest of the documentation in that record for today will support what we did.

Any current diagnoses should be reported as part of the decision. Every time. So I know you're thinking about this doctor, write it down. I know you're not going to send this person that you think has a kidney stone in for a CT with contrast because it could shut their kidneys down. I know you're thinking it even though you're not the nephrologist managing their chronic kidney disease. You know they have it. You know what stage it is and you know that it seems stable and that they're seeing an outside doctor. Chronic kidney disease, stage three, stable. Continue to see your endocrinologist, continue to see your nephrologist. M.E.A.T. chronic kidney disease stage three is going on the claim. Even though I might be seeing them for what I think is a kidney stone, or maybe it's not that at all, maybe it's gas. But anyway, that's what we need to get their intelligent brains to write down for us. I know you're thinking it. How can I get you to write it down?

And then remember, only document history of or past medical when they don't exist in their results. So maybe an old MI or a resolved CBA. We can put history codes. That's what those Z codes are for which we're going to get to here shortly. I'm talking a lot. We're almost there. So this is a source, but if you don't have an AHIMA login, you can't get to the source. It was open source, but they have since locked it down. But that is where I'm using this information from Monica Watson's article.

Coding capture. Remember chronic conditions. If they're reported properly, we need to capture them. Anything that receives care and management during that visit should be reported. Conditions that are no longer active should not be reported. Report history of if it's pertinent. If they're here and they're having chest pain and they have a history of an MI, that's pertinent. Or a history of GERD or a personal history of a GI bleed. But if they're coming in for chest pain and they have cataract replacement, you don't need to put that one on.

Remember this, this was a question. Documentation can be found in any section of the record during that face-to-face. So it doesn't have to be in the assessment or the plan. It can mean the subjective or the objective for you to be able to report it on the claim as long as you've met M.E.A.T. All right, gap analysis software is awesome for you to be able to find this. If you're in an ACO, they're giving you reports. But if you see patients at least once a year, that's simple. You can pull that out of your scheduling software. Prep for your visits ahead of time and maybe make yourself aware that this hasn't been going on on a claim yet this year. Put a sticky note might want to address this, doctor.

Medicare well visits. That's the key to capturing all this. You can get them all on your Medicare well visit claim. You don't have to address them and you get credit for it. And then coding audits, coding. Are the coders missing it? Are the doctors not documenting it? That's a really good way to see if you're missing

some of these. Do some coding audits and look at the documentation. Make sure that it's all getting captured according to the M.E.A.T. Real quick, Medicare well visit captures everything on the claim. Keeps your patience in your practice. Doesn't cost your patients a thing and it's a win-win. Last slide about coding audits. Use this not in a punitive fashion, but uncover opportunities. You can increase your teamwork between your coders, your billers, and your clinical staff, all your revenue cycle departments. It's going to ensure that your organization's getting correct reimbursement. It's going to protect against fraudulent claims, fraudulent billing activities because you're going to identify it and change your ways and fix things. Identify those areas before your payers do. So again, you can fix the problems and get it up to speed. Get your documentation where it needs to be.

Generally when you do a coding audit, you will find operational efficiency improvement, maybe one little nugget. It's going to improve your data quality. For external reporting to public health, population health and to your payer and internal use. So your admin team could run a report and say, "What are the biggest social determinants of health that we're having in our community? What are the biggest, the top three diagnoses in my community? Maybe I need to invest in a diabetic educator. Maybe I need to invest in a new mammo machine." This is where we're getting internal data use. And if you pay for an external audit, use what they did to enhance your current internal auditing because you're not selling it to someone else. And if you like the way they reported it back, use it to help your internal audit processes. Not hurting a thing. All right, we're switching to social drivers of health.

We have just about 10 slides left. We're getting there. So social determinants of health or social drivers of health are being used interchangeably in the world. Okay? It's the same thing. This is the healthy people 2030 website landing page, very interesting stuff. What is a social determinant of health? There are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes. And these social factors can impose significant barriers to a person's health and wellness. So just some examples, safe housing, transportation or lack of, racism, discrimination, violence, education, job opportunities and income or lack of, access to food and physical activities, polluted air and water, language or literacy skills. Can they speak the English language? Can they read and write? Those are all potential social determinants of health. I'm going to click on this link for utilization of Z codes.

This hasn't come out yet since I'm waiting for a new one to come out. But this is just a informational data highlight. And I want you to see right here. I'm going to blow this up. So when you're talking about Medicare beneficiaries, here's the top five most utilized Z codes. So very interesting top five Z codes. And we do know that from 2019, 2016 to 2019, our Z code reporting is going up. So that's good too. But I'm really anxious to see with all of the education and now we have a G code that this goes up even more, that we're screening. So here's on the next two slides are just the 10 different category codes for social determinants of health. So Z55 to Z59 are on the first screen and under Z59 there are 22 possible subcodes for problems related to housing and economic circumstances. That's a big one.

No, M.E.A.T. is not needed for annual wellness visit and the documentation needs to be in the note. If they have documented the diagnosis of CHF and hypertension, but have used the wrong codes, I do not have to query the provider? No. Yes, read your ICD-10 guidelines. It will tell you you have to use the right ones. Sorry, I'm catching these as we're going. So this is one section. I blew it up so you could read it and then there's five more on the next page. Five more. And in this one, the big winner is problems related to upbringing. So new codes come every year. I think this year they started with parent, step-parent, child, child, step-parent rivalry. So there are all these codes that are out there and available for us to report problems that are happening that could potentially lead to bad outcomes on a patient's life, right?

So coding guidelines, these are the 2024 guidelines. Section one, chapter B. Want to see a couple of things I want to show you here for the coders. There are a few exceptions when code assignment may be based on medical record documentation from clinicians who are not the patient's provider. What? We've been taught and taught and taught that unless the doctor writes the diagnosis, we can't use it. But we can for social determinants of health, absolutely can and we should. So here's your exceptions. And you can see social determinants of health and the other exceptions. Okay. On the next slide, same section of one C, social determinants of health, chapter 17. What I want you to see is for social determinants of health, chapter 21 that starts with letter Z. Code assignment may be based on medical record documentation from clinicians involved in the patient's care who are not the provider. Since this information represents social information rather than medical diagnosis, there is the reason why we can grab these and get them on the claim.

And we can even use patient self-reported documentation to assign those codes as long as it's signed off by either a clinician or anybody who's a nurse, anybody who's allowed to document in the chart. If they sign off on it, if it's scanned and your nurse signs off on it, you can use it. Because it's not medical diagnosis. But it does say if it is a medical diagnosis, you're going to need that part as well. So if you've got obesity, the doctor has to write obesity, we can go get the BMI. If it says alcohol intoxication, we can go get the blood alcohol level. It's right in the guidelines. And then this is just a slide that shows all of the conventions all on one slide. I just wanted to be able to show that to you.

So talking about documentation best practices, talk to your staff, educate them to screen and document or code, if they're coding data on their social determinants of needs. Ask them. Patients may not know to talk about non-medical issues with their doctor and they might need to be prompted. That's where a screening tool is wonderful. Use a health risk assessment, use a screening tool and document it wherever you need to, but make sure it's in today's note somewhere. It's associated with today's encounter in some fashion. Here's a sample top to bottom screening tool that is fabulous. I think it covers about everything you can think of.

Do you have difficulty understanding English? Are there times when you're hungry? Do you have problems paying for your utility bills or your house? Are you homeless or at risk of being homeless? Do you need help with transportation to the doctor, to the pharmacy, to the grocery store? They're asking about abuse or neglect or being unsafe at home work or school. Social isolation. How often do you see or talk to people? What's your highest level of schooling, your current work situation, and have you been unable to get your medication because there wasn't enough money to pay for it?

So that pretty much top the bottom. And if you have a patient answer this, whether it's on paper or some people have tablets in the lobby and they answer it, load it into the system. And we've got social determinants of health codes for all of those. Got a lot of them.

All right. Coding capture. Again, coders need to watch for it. You need to look at diagnosis codes in the problem list. If they're saying that the patient is homeless, we can add this and use self-reported data. We can add this. It's not medical, it is social. Anything in the patient's record for that date encounter can be incorporated into the record and we can get that Z code. And number four on this slide, Z codes are not optional. We've got 25 slots on your claim. Of course you're going to have to get the medical codes first, but please, please, please don't overlook the Z codes. They're not optional.

So let's review some requirements to get these codes on a claim. Always all first and secondary diagnosis codes have to be reported to the highest level of specificity. So we as clinical documentation improvement specialists, we're the CDI team in our clinics. Have those conversations with your providers, help them help you help the patient by telling the whole story every time the patient sees the doctor. That record is always going to validate those codes by the physician or the care team. If you're

ever concerned that you shouldn't report it, look at the record as if you were an auditor. Is it validated in the record for today's visit? Then you can feel confident in reporting it.

Remember for HCC's, your diagnoses have to be re-documented on an annual basis, January one to 12/31 in order to be included on that claim and to be counted for HCC assignment towards your risk adjustment factor. And then remember, document and report all social determinants of health data, whether it's self-reported or captured by any member of the team using those Z codes. I got some really great links here. I'm just going to buzz through. Z codes to create RAF's. There are some starting to create RAF scores. So Z codes are, some are on the HCC list, very few, but there are some Z codes that may map over to HCC, but a lot of it is left-leg amputee status. Those types of things would maybe drive more of an HCC, but there are some Z codes that would drive to a risk.

Social determinants of health. Okay, if the diagnosis is only used to report, it should not be considered for medical decision-making. Exactly. So Laura, you're right on the medical decision-making table. If you want to get a moderate level of medical decision-making under risk, the diagnosis or treatment is significantly limited by social determinants of health. You have a moderate risk in your evaluation and management. You have to get one more in either the number of problems or the data. But yes ma'am, very good. It drives your E&M level if you document properly. Okay, that's not me. What does the resource you use? Oh, here's all the resources. We don't have coders, but we are certified billers. Can we add the diagnosis codes? Oh my gosh, that's a good question.

Social determinants. If you're confident, yes. Anybody else? No, it's very risky to have billers putting ICD codes or modifiers on a claim. But if you're properly trained and you have a process and it's written down, I would be watching your risk management. I'm not saying no, but be careful with that because we don't want you putting regular diagnosis codes on a claim. Very slippery slope, but I'm not opposed to it if that's how it's getting captured. I just want you to be sure you're cleaning that, walking through your risk management with that. Medicare does not, no, Medicare will not deny Z codes. I'm not sure who's doing that to you Erica, but that is absolutely incorrect. So if you've got Medicare denying a Z code, I don't know what's going on. You can email me because that's not right.

Okay. Our new patient reg form has a housing question. It is completed and signed off by the patient at their initial visit. If homelessness, wow is reported by the patient, can a coder pick the appropriate? Yes. And you should. Yes, yes, yes. Perfect example. Can HCC be captured by telehealth visits? Yes. Documentation. Documentation is doing it. Good job. Capture all self-reported conditions. If the patient says I had previous depression or hypertension, that is not, that's a medical, if you don't have M.E.A.T. documentation, you should not be reporting that. This is social. Be careful with that one.

Z codes. When they ask if you smoke or drink alcohol, I don't know that there's a Z code for a tobacco user, but there's a G code for it. I don't think there's a Z code for if they say they smoke or drink. I suppose you could. It's just a social, so yeah. Yes, G0136. If you're doing a screening, that is the code. It is reimbursable a little bit. It will not raise your all-inclusive rate, but you can get a percentage extra of your co-insurance.

Category three, two codes will be denied on an HMO. Oh my gosh. So you know what? When we're getting into contracts with commercial payers and commercial payers Part C plans, that would be tough. So that one there, you're going to have to fight back and forth with your plan. Tobacco use, if you're having tobacco use, I would ask if they are having tobacco dependence, because I get Z72.0 a lot when they're actually nicotine dependent on cigarettes. I don't like the Z72.0 very much. That would be a good opportunity to talk to your provider and ask if they're nicotine dependent.

Okay, ICD-10. If they tell you they're obese or underweight as the doctor's medical diagnosis, you could put the BMI on the claim. Just go to the guidelines. Go into the guidelines. That's your rule on that. For

social determinants of health, should only a provider enter the data? No. Anybody who's allowed to document in the note can document it in the note. Codes for Medicare as a provider need to report treatment care plan. Oh boy, you just went out of my area of expertise. I know that computer health integration, but I can't answer that one. That one is out of today's scope. That doesn't mean I couldn't answer it offline.

All right, so let's go here to the final page. This is where you find me. Jking@archprocoding.com. We have a website with lots of recorded webinars, live events, and we have Facebook page too. So when big things happen, we try to report those out on Facebook as well. So thank you for your time and attendance. We made it. We were a little over. Lots of good interaction and I appreciate you guys because that makes everybody learn when you interact so thank.

PART 4 OF 4 ENDS [01:37:42]