ICD-10 Guidance Document

NewYork-Presbyterian

Resolution of ICD-10 transition period billing scenarios

A NewYork-Presbyterian Hospital guidance document for the healthcare industry mandated transition to the ICD-10 diagnosis (CM) and procedure (PCS) coding system effective October 1, 2015.

1. Statement of Purpose/ Critical Success Factors

The purpose of this guidance document is to provide direction on enablement of payer and/or service specific billing scenarios that are likely to manifest themselves during the ICD-10 transition period. The transition period is generally defined as September 1, 2015 through November 30, 2015 though operating and systemic idiosyncrasies may require such guidance to expand beyond this time.

Billing, independent of ICD-10 is the conduit that converts delivered and documented patient care services into cash for the hospital. The bill generation and claim submission activity is largely an automated process that enables the translation of care into billable information capable of supporting accurate and timely payment. That billable information populates an electronic (or paper) claim form with numerous demographic, financial, and clinical data elements including ICD-9 diagnosis and procedure codes.

The following readiness guidance is provided as a general means to identify and address the operating idiosyncrasies that are likely to manifest during the course of the transition period and mitigate some of the short-term risks associated with the implementation of ICD-10. Given the complexity, diversity and number of portals to entry throughout NYP, it is possible that this guidance may not cover the full spectrum of scenario and circumstance within each individual department. As such, it is expected that such guidance provide a general awareness of the requirements and desired outcomes. Management should leverage their unique understanding of their respective operating areas to apply approaches and methods to meet the requirements and achieve those desired outcomes.

2. Statement of Guidance

It is the intent of NewYork-Presbyterian Hospital to transition to the industry mandated ICD-10 diagnostic and procedure coding system on October 1, 2015. Effective for said dates of service/discharge, NYP shall be required to submit medical claims for consideration of payment by third party insurance carriers with applicable ICD-10 diagnosis and procedure (as applicable) codes. Supporting that consideration of payment requires that the necessary and requisite billing and claim submission activities are similarly performed with consideration for and in alignment with the aforementioned date of service sensitivity and any payer specific claim submission requirements. Such activities may include but are not necessarily limited to split billing and even ICD-9 billing in the event a payer that is unable or not legally required to accept ICD-10 codes. The following payer and/or service specific billing scenarios have been identified in advance of the ICD-10 implementation date of October 1, 2015.

Patients admitted to an inpatient setting prior to October 1, 2015, discharged after October 1, 2015, and covered under Medicare Part B benefits only. Per the Centers for Medicare & Medicaid Services' MLN Matters article number SE1408 revised on June 27, 2015, providers shall be required to split claims spanning the ICD-10 implementation date so that all services provided prior to October 1, 2015 are coded, billed, and submitted using ICD-9 codes and all services provided on or after October 1, 2015 are coded, billed, and submitted using ICD-10 codes. Such instances shall require the Hospital's Health Information Management (HIM) department to supply both ICD-9 and ICD-10 (i.e. – dual coding) codes so as to effectuate timely, accurate, and compliant billing. As part of the monitoring effort, the ICD-10 Project Management Office (PMO) shall use reporting tools sourced from the Hospital's registration and billing system (Eagle) to proactively identify these cases in an effort to ensure the necessary dual coding activities take place in advance of initial billing and so as to prevent billing errors and delays in claim submission.

Patients admitted to an inpatient rehabilitation setting prior to October 1, 2015, discharged after October 1, 2015 and covered under New York State Medicaid benefits (Note: At this time, only Healthfirst has confirmed that it will follow New York State Medicaid guidelines for both its Medicaid and Child Health Plus product lines). Per the New York State Department of Health's eMedNY frequently asked questions (FAQ) updated on June 11, 2015, non-DRG claims excluding inpatient psychiatry need to be split billed. Such instances shall require the Hospital's Health Information Management (HIM) department to supply both ICD-9 and ICD-10 (i.e. – dual coding) codes so as to effectuate timely, accurate, and compliant billing. As part of the monitoring effort, the ICD-10 Project Management Office (PMO) shall use reporting tools sourced from the Hospital's registration and billing system (Eagle) to proactively identify these cases in an effort to ensure the necessary dual coding activities take place in advance of initial billing so as to prevent billing errors and delays in claim submission.

Patients seen and treated in outpatient settings prior to October 1, 2015, receive services ordered as a result of that outpatient encounter after October 1, 2015, and covered under Medicare part B benefits. Per the Centers for Medicare & Medicaid Services' MLN Matters article number SE1408 revised on June 27, 2015, providers shall be required to split claims spanning the ICD-10 implementation date so that all services provided prior to October 1, 2015 are coded, billed, and submitted using ICD-9 codes and all services provided on or after October 1, 2015 are coded, billed, and submitted using ICD-10 codes. Such instances, generally defined as outpatient encounters having 'from-through dates' spanning more than one day shall require the Hospital's Health Information Management (HIM) department or other coding entity or source to supply both ICD-9 and ICD-10 (i.e. – dual coding) codes so as to effectuate timely, accurate, and compliant billing. As part of the monitoring effort, the ICD-10 Project Management Office (PMO) shall use reporting tools sourced from the Hospital's registration and billing system (Eagle) to proactively identify these cases in an effort to ensure the necessary dual coding activities take place in advance of initial billing so as to prevent billing errors and delays in claim submission.

Patients seen and treated in outpatient settings prior to October 1, 2015, receive services ordered as a result of that outpatient encounter after October 1, 2015, and covered by New York State Medicaid benefits or a Medicaid managed care plan providing such benefits. Per the New York State Department of Health's eMedNY frequently asked questions (FAQ) updated on April 15, 2014, Clinic APG Episode of Care with multiple dates of service where the through date is on or after October 1, 2015 must be coded as ICD-10 for **all dates of service.** Per separately defined continuation of service guidelines, such instances are likely to manifest themselves as a result of ancillary services ordered as a result of the pre-October 1, 2015 outpatient encounter being provided on or after October 1, 2015. The timing of such activity typically results in the submission of adjustment claims to account for changes in the originally submitted and paid claim. These instances shall require the Hospital's Health Information Management (HIM) department or other coding entity or source to supply both ICD-9 and ICD-10 (i.e. – dual coding) codes so as to effectuate timely, accurate, and compliant billing. As part of the monitoring effort, the ICD-10 Project Management Office (PMO) shall use reporting tools sourced from the Hospital's registration and billing system (Eagle) to proactively identify these cases in an effort to ensure the necessary dual coding activities take place in advance of initial billing so as to prevent billing errors and delays in claim submission.

Patients covered by one entity (i.e. - insurance carrier) required and/or capable of receiving ICD-10 diagnosis and procedure codes and an additional entity not required and/or capable of receiving ICD-10 codes. There are no known entities at this time that have indicated an inability or declination to receive, accept, and process ICD-10 diagnosis and procedure codes. This space is reserved for future guidance as such entities are identified.

3. Audience & Applicability

This guidance applies to all operating, administrative, and support areas' staff, management, and clinical professionals supplying revenue cycle function and support to bill generation and claim submission activities. This may include but is not necessarily limited to Health Information Management, Coding & Documentation Improvement Specialists, Revenue Cycle Support, Patient Financial Services, Information Technology Services

4. Standards

This guidance is intended to support the standardized and compliant billing protocols as defined by federal and/or state regulatory authority, as well as any known or published protocols supplied or provided by private insurance benefits providers with which NYP engages for the purposes of healthcare claim consideration and payment.

5. Exclusions

There are no identified exceptions to this guidance as currently stated.

6. Definitions

ICD-10 CM/PCS – The International Classification of Diseases system developed by the World Health Organization and adopted by the United States for the purpose of codifying conditions and services provided to patients in the healthcare setting. As part of a federal mandate, all healthcare providers are required to transition from the 9th edition of the code set (i.e. – ICD-9-CM/PCS) to ICD-10 by October 1, 2015.

Adjustment claim – The resubmission of a healthcare claim encounter previously paid by a third party insurance carrier due to changes in any element of claim information including charges and diagnosis, and procedure codes. Adjustment claims are typically identified with a CMS UB-04 bill type value of 117 (inpatient) or 137 or 147 (outpatient).

Ancillary services – are generally defined as additional tests, exams, or other healthcare services provided as a result of the evaluation and management of a patient and his/her presenting condition(s) for the further evaluation and/or conformation of a diagnosis (e.g. – lab, radiology, vascular, nuclear medicine, etc)

Ambulatory Payment Group (APG) – a reimbursement methodology implemented by the New York state Department of Health's Medicaid program to reimburse hospital providers for select outpatient healthcare encounters including hospital based clinics and emergency department visits.

Dual coding – the provision of both ICD-9 and ICD-10 diagnosis and (as applicable) procedure codes to a healthcare encounter.

Split billing – the deliberate separation of the patient care services on a claim for a give healthcare encounter based on federal, state, or other entity claim submission requirements and criteria.

7. Related Materials/Tools

Training and readiness aids for specific applications to which this guidance is applicable and tools to assist in the conversion of ICD-9 codes to equivalent ICD-10 codes shall be available on the NYP ICD-10 AnTENna website at http://nyplearningcenter.org/apps/eLearning/cms/icd10/.

8. Guidance Review Period

This guidance shall be reviewed and revised as necessary for the duration of the ICD-10 transition period previously defined.

9. Guidance Effective Date

This guidance is effective as of September 1, 2015.

10. Resources

Questions regarding the interpretation and/or implementation of this guidance may be directed to the Project Director for ICD-10 implementation or by e-mailing ICD-10Help@nyp.org. Additional information will be provided on the NYP ICD-10 AnTENna website at http://nyplearningcenter.org/apps/eLearning/cms/icd10/.