ICD-11 CM Overview and Review of ICD-10 CM Updates

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Disclaimer: *This presentation is offered as guidance to NEPHO providers and office administration. If you are a BILH employed practice please follow up with your practice Leadership on guidance reviewed during this presentation.*

Agenda

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World Health Organization (WHO) Defined

WHO is WHO

- Founded in 1948: WHO is the United Nations agency that connects nations, partners and people to promote health, keep the world safe and serve the vulnerable – so everyone, everywhere can attain the highest level of health.
- WHO is an organization of 194 Member States. The Member States elect the Director-General, who leads the organization in achieving its global health goals.
- The Team of 8000+ professionals includes the world's leading public health experts, including doctors, epidemiologists, scientists and managers. Together, WHO coordinates the world's response to health emergencies, promote well-being, prevent disease, and expand access to health care. By connecting nations, people and partners to scientific evidence they can rely on, WHO strives to give everyone an equal chance at a safe and healthy life.
- WHO are professionals committed to integrity and excellence in health. They focus on collaboration and a steadfast commitment to science, they are the organization trusted to care for the world's health.

Background of ICD-11 CM

- WHO recently released the 11th edition of the International Classification of Diseases (ICD-11). This release was presented at the World Health Assembly on May 25, 2019 for adoption by member states, and will come into effect on January 1, 2022.
- According to the WHO, the 11th revision is the result of a collaboration with clinicians, statisticians, epidemiologists, coders, classification, and IT experts from around the world. ICD-11 is a scientifically rigorous product that accurately reflects contemporary health and medical practice, and represents a significant upgrade from earlier revisions.
- With the increasing need to operate in an electronic environment, as well as the need to capture more information for morbidity-use cases. ICD is the international standard for systematic recording, reporting, analysis, interpretation, and comparison of mortality and morbidity data.

Goals of ICD-11 CM

- Ensure that ICD-11 will function in an electronic environment by:
  - Presenting a digital product
  - Providing linkage with terminologies
  - Defining ICD Categories by “logical operational rules” on their associations and details
  - Supporting electronic health records & information systems
- Provide a multi-purpose and coherent classification for:
  - Mortality, morbidity, primary care, clinical care, research, public health
  - Consistency & interoperability across different uses
- Deliver an international, multilingual reference standard for scientific comparability:
  - English, French, Spanish, Russian, Chinese, Arabic
- ICD–11 will allow countries to count and identify their most pressing health issues by using an up-to-date and clinically relevant classification system. Health conditions and accidents are assigned ICD–11 codes, resulting in data that can be used by governments to design effective public health policies, and measure their impact, or used for clinical recording.
- ICD–11 lowers the costs for using ICD because correct use requires less training and less time for coding, and as such allows the implementation of standard reporting in places where it has not been possible to use ICD before. It is free for use in all countries, as a package with user guides and tools, providing inexpensive coding of patient encounters in the clinical setting.

Basic Structure of ICD 11 CM

- ICD 11 CM contains 55,000 codes where ICD 10 CM contains 14,400
- ICD 11 CM will have 28 chapters, compared to 22 in ICD-10 CM.
  - Additions include chapters for immune system diseases, sleep-wake disorders, traditional medicine, developmental anomalies, sexual health, and functioning assessment, as well as a better representation of cancers, devices, medications, substances, severity, and causes of injuries.
- ICD-11 CM enables more straightforward coding. Simple coding can be done as well as coding of complex clinical detail.
- The range of potential codes is 1A00.00 to ZZ9Z.ZZ.
- ICD-11 CM also introduces two noteworthy features — extensions and clustering — which enable two kinds of post-coordination (linking multiple codes to describe a concept) and the addition of specific detail to coded entities. EXAMPLE:
  - Diagnosis: Left hip osteoarthritis with chronic pain
    - FA00.Z *Osteoarthritis of hip, unspecified*
  - Post-Coordination:
    - Laterality (use additional code, if desired): XK8G *Left*
    - Has manifestation (use additional code, if desired): MG30.3 *Chronic secondary musculoskeletal pain*
  - Cluster: FA00.Z&XK8G/MG30.03

Examples of ICD-11 CM Coding

- Essential hypertension, unspecified:
  - ICD-9-CM 2015: 401.9 *Unspecified essential hypertension*
  - ICD-10-CM 2021: I10 *Essential (primary) hypertension*
  - ICD-11: BA00.Z *Essential hypertension, unspecified*
- Diabetes mellitus, type II, with left diabetic cataract:
  - ICD-9-CM 2015: 250.50 *Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled*, and 366.41 *Diabetic cataract*
  - ICD-10-CM 2021: E11.36 *Type II diabetes mellitus with diabetic cataract*
  - ICD-11: 9B10.21&XK8G/5A11
    - 9B10.21 *Diabetic cataract*
    - XK8G *Left*
    - 5A11 *Type 2 diabetes mellitus*

ICD-10 2022 Updates

- The proposed ICD 10 updates include 153 new diagnosis codes, 22 revised codes, and 30 deleted codes.
- Proposed Biannual Updates in 2022 – October 1, 2021 & April 1, 2022.
- Top Highlights in this update include:
  - New COVID-19 Codes that were recently added: including **J12.82, M35.81, M35.89, Z11.52, Z20.822,** and **Z86.16**.
  - Chapter 13 accounts for 35 ICD-10-CM code changes, including an update to the diagnosis code for low back pain (**M54.5**). It has been expanded to distinguish vertebrogenic low back pain (**M54.51**) from other types of low back pain.
  - Several changes were made in Chapter 18; six new specific codes for coughs (**R05**) were added, including acute, subacute, chronic, cough syncope, other specified and unspecified.
  - Most changes occurred in Chapter 19, including new codes for traumatic brain compression (**S06.A-**) and poisoning by cannabis (**T40.71-**) and synthetic cannabinoids (**T40.72-**).

Social Determinants of Health (SDOH) Overview

- The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways:
  - Income and social protection
  - Education
  - Unemployment and job insecurity
  - Working life conditions
  - Food insecurity
  - Housing, basic amenities and the environment
  - Early childhood development
  - Social inclusion and non-discrimination
  - Structural conflict
  - Access to affordable health services of decent quality

SDOH Overview (continued)

- Inequities in health are socially determined, preventing poorer populations from moving up in society and making the most of their potential.
- Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
- Action requires not only equitable access to healthcare but also means working outside the healthcare system to address broader social well-being and development.
- ***"Health equity is defined as the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically".***

Risk Adjustment Coding Capture Key Points

- ICD-10 codes mapped to Hierarchical Condition Category (HCC) codes are used to determine the severity of illness of patient panels.
- New payment models include risk-adjustment factors for patient health status.
- Physicians should report not only the diagnosis codes that describe why a patient was seen but also any diagnosis codes associated with chronic conditions that affect treatment choices.
- Patient risk scores are reset each year, so physicians should comprehensively code chronic conditions at annual visits.
- Risk-adjustment models assign each patient a risk score based on demographics and health status.
- Demographic variables may include age, gender, dual Medicare/Medicaid eligibility, whether the patient lives at home or in an institution, and whether the patient has end-stage renal disease.
- Health status is based on the diagnosis codes submitted on inpatient, outpatient, and professional claims in a calendar year.
- Certain diagnosis codes map to disease groups (HCCs). Demographics and HCCs are weighted and used to calculate a risk-adjustment factor (RAF) score.
- The risk score is reset each contract year for individual patients, and only diagnoses reported within that year are used to calculate the score.
- Individual claims are paid at the contracted rate, but payers use the group's overall risk score to calculate future payment rates and bonuses.

Risk Adjustment Coding Capture Best Practice

- **Educate Providers**: Physicians should be educated on how risk-based contracts work and the importance of HCC coding and the need for proper documentation for patients with chronic conditions. Clinic staff should also be educated about the tools and workflows for patient management and reporting.
- **Identify most Frequently Encountered Patient Conditions**: Practices should be familiar with the most prevalent HCCs, identify the codes most relevant to them, and ask physicians to focus on these conditions.
- **Prepare for each Patient Visit**: When seeing complex HCC patients, physicians should prepare in advance of the appointment. This will help them document and address chronic conditions more accurately and document their findings in the medical record. (Pre-Visit Coding Review)
- **Prepare an Accurate Problem List**: Optimize the EMR and ensure an accurate problem list by removing duplicative and inactive diagnoses, and using a diagnosis preference list to include HCC gaps will help with annual capture. (Epic has this functionality to highlight HCC gaps)
- **Document Chronic Conditions even if not Treating them**: Even if the physician is not seeing a patient for a chronic condition, it should be documented. For instance, if an orthopedist is treating a patient for a knee condition and the patient has diabetes, the physician should document diabetes in the medical record as it will affect the patient's care plan.

2021 Risk Adjustment Coding Focus

- Appropriate capture and documentation of HCC codes for patients is essential for determining accurate risk adjustment scores.
- All chronic conditions should be monitored. Medicare & Commercial payers require that all qualifying conditions be documented at least once a year.
- Physicians must thoroughly report a patient's risk adjustment diagnosis based on clinical medical record documentation from a face-to-face encounter.
- The patient medical record should be coded accurately and accompanied by supporting documentation about the status of each condition.
- To capture the most accurate HCC code, physicians must document all active chronic conditions including conditions that are relevant to the patient's current care, i.e., the diagnoses being monitored, evaluated, assessed/addressed, or treated. MEAT - **(Monitor, Evaluate, Assess, Treat).**
- Each diagnosis should have an assessment and plan, and treatment and level of care must be acceptable.
- Documentation linked to a non-specific diagnosis, as well as incomplete documentation, can negatively impact patient care and also reimbursement for the services rendered.

Put It All Together: Coding Examples

Select not only the diagnosis codes that describe why the patient was seen but also codes for any chronic conditions that affected treatment choices.

Examples:

- A patient with diabetes presents with severe poison ivy. The physician discusses the diabetes with the patient in deciding whether to use prednisone and documents it in the assessment. The physician should report poison ivy first and diabetes second.
- A patient followed by nephrology for chronic kidney disease (CKD) is seen by his family physician for hypertension, which is not well controlled. The physician considers and documents the CKD when selecting hypertension treatment, and should report hypertension first and CKD second.
- A patient with multiple chronic diseases presents for an annual exam. The physician reviews and documents the status of chronic diseases treated within the practice and by other providers.

If a patient has a serious chronic condition with a manifestation or complication that has its own code, use that code rather than an unspecified code.

Example:

- Code “Type 2 diabetes with retinopathy” instead of “Type 2 diabetes, uncomplicated” or “Varicose veins with inflammation or ulcer” rather than “Varicose veins, unspecified.”

Resources

- Shawn Bromley, NEPHO Director Contracting and Operations – Lead Coding Initiatives – shawn.m.bromley@lahey.org or 978-236-1704
- Jessica Bryan, NEPHO Coder – jessica.m.bryan@lahey.org
- https://yes-himconsulting.com/icd-11-overview/
- https://www.homestatehealth.com/content/dam/centene/home-state-health/pdfs/HSH_AWVGuide_HealthHistorySummary.pdf
- https://www.azcompletehealth.com/content/dam/centene/az-complete-health/pdf/provider/news_items/508_Annual%20Wellness.pdf
- https://www.medicare.gov/coverage/yearly-wellness-visits
- https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3
- https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/
- https://www.outsourcestrategies.com/blog/risk-adjustment-and-hcc-coding-look-at-best-practices.html