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Ohio Medicaid

Quality Monitor

What Providers should be doing for ICD-10

1. Assess, remediate, and test.

- Conduct ICD-10 needs assessment.
  - -Where are ICD-9 codes currently used?
- Remediate/update your policies, procedures, reports, and systems (billing software, EHRs, etc.) in preparation for ICD-10 implementation on October 1, 2015.
  - - What are the top 25 ICD-9 codes used today. Familiarize yourself with the ICD-10 codes.
  - - Have you updated your "superbill?"
- Test, test, test!
  - -Test internally.
  - -Test externally. This includes:
    - -vendors (EHRs, etc.)
    - -clearing houses/trading partners
    - -Medicaid managed care plans
    - -Verify that your vendors and clearing houses/trading partners are testing with Ohio Medicaid.

2. Educate your staff and yourself about ICD-10

- Determine staff training needs. Practice coding in ICD-10
  - - Can you code a claim using a current medical record? Providers have indicated that coding staff discovered that practitioners need to include more detailed information in the medical record in order for the coder to properly code the claim using ICD-10.
- Pay attention to communications from CMS, Ohio Medicaid, Medicaid managed care plans, provider associations, & trading partners.
  - - CMS has created the Road to 10 website (www.roadto10.org). Please visit the Road to 10 website to find useful information and resources to help your practice transition to ICD-10 by October 1, 2015.
- Take advantage of free training resources.
  - - Ohio Medicaid is offering CollabT: A CMS ICD-10 Coding Practice Opportunity for Ohio Medicaid Providers. CollabT is an on-line tool that offers medical coders an opportunity to practice ICD-10 coding and receive instantaneous feedback on their coding efforts (claims adjudication testing is not part of CollabT in Ohio). There is no cost for Ohio Medicaid providers to practice ICD-10 coding in CollabT. If your organization would like to enroll, please review information at: http://medicaid.ohio.gov/Portals/0/Providers/Billing/ICD10/Updates/CollabT-415.pdf.

3. Stay up-to-date on Ohio Medicaid ICD-10 implementation.

- Ohio Medicaid ICD-10 webpage: www.medicaid.ohio.gov/PROVIDERS/Billing/ICD10.aspx.
  - - ICD-10 Transition Information for Providers & Staff (TIPS).
  - - Billing Guidance TIPS are posted monthly.
- Ohio Medicaid MITS web portal and fee-for-service remittance advice banner messages.
- E-mail Ohio Medicaid ICD-10 questions to: ICD10questions@medicaid.ohio.gov.
- See Ohio Medicaid managed care plan (MCP) ICD-10 webpages; each MCP has their own ICD-10 webpage.

4. Be cautious of where you receive Ohio Medicaid ICD-10 information; inaccurate information has been disseminated.

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Coding Corner

ICD-10-CM CODING GUIDELINES FOR PREGNANCY

In this article of the Coding Corner, we would like to continue to review the changes to the Official Coding Guidelines that have taken effect with the implementation of ICD-10-CM in October of 2015.

CHAPTER 15: PREGNANCY, CHILDBIRTH AND THE PUERPERIUM (O00-O9A)

Codes have been moved from other chapters in ICD-9-CM to Chapter 15 in ICD-10-CM.

For example, encounter for supervision of high-risk pregnancy has been moved from the Supplementary Classification of Factors Influencing Health Status and Contact with Health Services to ICD-10-CM Chapter 15, to category code O09.

The following is an example of a change to the Coding Guidelines that will impact how to code/ sequence the diagnosis of anemia associated with malignancy once we begin to code with ICD-10-CM:

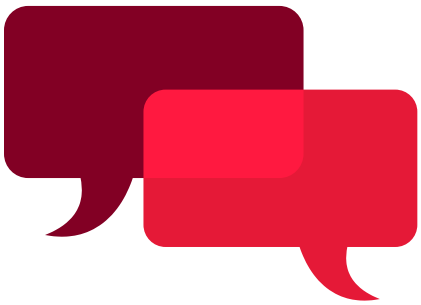
In the Official Coding Guidelines for ICD-9-CM for Chapter 11 (pregnancy) and the assigning the fifth-digit, categories (640-648, 651-676) have required fifth digits, which indicate whether the encounter is antepartum, postpartum and whether a delivery has also occurred. The fifth-digits on each code should be consistent with each other. For example, should a delivery occur, all of the fifth-digits should indicate the delivery.

In the Official Coding Guidelines for ICD-10-CM for Chapter 15 (pregnancy), the episode of care (delivered, antepartum, postpartum) is no longer the axis of classification, but rather the trimester in which the condition occurred. Because certain obstetric conditions or complications occur during certain trimesters, not all conditions include codes for all three trimesters. And some codes do not include the trimester classification at all because the condition always occurs in a specific trimester, or the concept of trimester of pregnancy is not applicable.

- 1st trimester = less than 14 weeks 0 days
- 2nd trimester = 14 weeks 0 days to less than 28 weeks 0 days
- 3rd trimester = 28 weeks 0 days until delivery

NOTE: At the beginning of Chapter 15, there is a note which indicates that when specifying the week or weeks of pregnancy, to use an additional code from category Z3A, weeks of gestation (Z3A.00-Z3A.49).

Due to the implementation of the ICD-10-CM coding system, it is imperative that the ICD-10-CM Coding Guidelines are reviewed by the coding staff so that they are aware of the changes to ensure appropriate code assignments are made when billing with ICD-10-CM.



Medical Director Dialogue –

The CMS Two Midnight Rule and The Ohio Department Of Medicaid Inpatient Admission Order Requirements

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What is the two midnight rule?

CMS has established a two midnight benchmark for physicians to use in determining patient status for inpatient or outpatient care. CMS specifies that when the physician expects the patient to require care that crosses two midnights and orders admission based upon that expectation, inpatient status is generally appropriate. Conversely, CMS specifies that hospitals stays in which the physician expects the patient to require care for less than two midnights, inpatient status is generally inappropriate. CMS also states that an inpatient admission is appropriate for cases involving procedures on Medicare's inpatient-only list, regardless of length of stay. They clarify that certain situations, such as deaths or transfers, are also exceptions to the two midnight rule.

To what hospitals does this apply?

The two midnight rule applies to all inpatient acute care hospitals, including Long Term Care Hospitals (LTCH) and critical access hospitals (CAH). However, it does not apply to inpatient rehab facilities (IRF) as there are very specific regulatory guidelines for admission to these units and facilities.

Does the two midnight rule apply to all payers?

NO. The two midnight rule only applies when traditional Medicare is the primary payer.

Does ODM recognize the two midnight rule?

NO. ODM uses clinical criteria based upon the severity of illness to determine the medical necessity of the inpatient level of care. Neither the intensity of service nor length of time spent at a facility can establish medical necessity.

Who can order inpatient admission?

The inpatient admission order can be written by a physician with admitting privileges who is involved with the case. It does not have to be the attending physician. A hospitalist or ED physician with admitting privileges can write the admission order. If the ED physician does not have admitting privileges, a verbal order must be obtained from a physician with admitting privileges.
Verbal admission orders must be authenticated/countersigned prior to discharge.

What is required for a legal order for admission to the INPATIENT Level of Care?

Progress notes and other clinical documentation in the medical record must support the inpatient admission. In addition, the medical record must contain a valid and legal inpatient admission order with a physician signature. Collectively, these requirements are necessary to support inpatient admission. Utilization review of inpatient admission orders will focus on these requirements:

1. The Inpatient Admission Order must be obtained at admission, must be consistent with and supported by the physician admission and progress notes, and must be furnished by a physician or other practitioner who is:

i. licensed by the State to admit inpatients to hospitals,

ii. granted admitting privileges by the hospital to admit inpatients to that specific facility, and

iii. knowledgeable about the patient's hospital course, medical plan of care, and current condition at the time of admission.

2. In accordance with Ohio Administrative Code (OAC) 5160-2-02, the order must be written by a physician. Permedion, therefore, specifically looks for an area or a page properly designated as Physician Orders and does not accept statements made in progress notes, etc. when determining if a hospital adhered to the OAC rule.

3. Standards of Care dictate that a complete inpatient admission order includes: date, time, level of care, diagnosis, physician of record, and signature of the admitting physician.

4. When coming from the ED, the ED records will often have a final disposition box where the ED physician will check off the final disposition such as discharged, admit, etc. This box being checked does not count as a valid admit order; however, if the ED physician writes in the ED Physician Orders section: "Admit to Inpatient Level of Care – Dr. X – Dx: Acute Renal Failure—4West," that would qualify as a valid admit order.

5. A single attending physician must be designated; one cannot admit a patient to a "group" practice. Please also note that the attending physician must be enrolled with Ohio Medicaid in order to meet the Ordering, Referring, Prescribing (ORP) requirements.

6. Many hospitals are now going to a "Case Management Protocol" where the case management nurse specialists are assigning the status of the patient (Inpatient vs Observation) based upon clinical criteria according to national guidelines, such as Milliman Care Guidelines. These types of protocols are acceptable; however, the determination and subsequent order for admission, to either Observation status or Inpatient status, MUST be countersigned, timed and dated by a physician with the concurrence of the attending physician.

7. The order must indicate the level of care to which the patient is being admitted: Outpatient, Observation, or Inpatient. The complete wording of the level of care order is the best practice for establishing the correct level of care.

8. Electronic orders are acceptable. However, auto-populated date and time stamps at the top of the electronic orders are confusing and not as definitive as a date and time stamp located directly next to the physician's electronic signature.

9. In accordance with OAC 5160-2-02, an order to admit to inpatient status may NOT be written on the day of discharge; however, in instances when, on the day of admission, a patient dies or is transferred to another inpatient unit within the hospital, to another hospital, or to a state psychiatric facility admission on the day of discharge may be appropriate.

10. When there are conflicting orders with respect to patient status (observation vs. inpatient), the last order written is considered to be the valid one.

Of the many utilization issues that ODM and Permedion encounter every day, one of the most consistent items concerns a basic element of charting and documentation: The Admission Order. While realizing that every facility is going to have a different methodology, everyone needs to be on the same page as to what constitutes a physician order for admission to inpatient status or observation level of care. As we move forward with cost consciousness in the healthcare reform environment, assigning the most appropriate level of care through a valid and complete order to a given patient encounter episode will take on an ever increasingly important role.

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