AGENDA

- Introduction
- General Information
- Clinical Workflow
- Features
- ICD-10 Testing
- What you Need to Do
General Information

- The ICD-10 code set has been expanded from five positions (first one alphanumeric, others numeric) to seven positions. The new codes use alphanumeric characters in all positions, not just the first position as in ICD-9.

- As of the latest version, there are 68,000 existing codes, as opposed to the 13,000 in ICD-9.

- The new code set provides a significant increase in the specificity of the reporting, allowing more information to be conveyed in a code.

- The terminology has been modernized and has been made consistent throughout the code set

- **No Clear Mapping Between ICD-9-CM and ICD-10-CM Code Sets**
ICD-10 Why Now?

- ICD-9 is outdated, has been in use since 1979, the United States is one of the last developed countries to switch over to ICD-10.
- Some 25 countries have already been using ICD-10 codes, here is a sample of the countries and the year that ICD-10 was adopted.
  - United Kingdom adopted them in 1995
  - Brazil started adopting them in 1998
  - France adopted them in 1996
  - China adopted them in 2002
  - Germany adopted them in 1998
- This will allow us to compare our data with international data to track diseases, the spreading of them and treatment options and outcomes.
- Includes updated medical terminology and classification of diseases.
- Flexible to incorporate emerging diagnoses and procedures.
Better equipped to capture advances in Medicine and Medical Technology.
Provides codes to allow comparison of mortality and morbidity data.
Flexible for adding new codes.
Incorporating greater specificity and clinical information will result in:
  • improved ability to measure health care services
  • ability to conduct public health surveillance
  • decreased need to include supporting documentation for claims
  • supports comprehensive quality data reporting
Ensures more accurate payment for:
  • new procedures
  • improved disease management
Features
The Harris CareTracker Application is currently being updated to accommodate the ICD-10 requirements. This includes changes to the product user interface, new feature and functionality surrounding ICD-10 CMS requirements, updates and testing of ICD-10 code validation, interface testing, and E2E tests with our clearinghouse.

- **Reports**
  - ICD-10 Payer List
  - Top Diagnosis Code by Company
- **Administration**
  - Group DX Code Settings Maintenance
  - New Encounter From Maintenance
- **Visit/Charge Entry**
  - Dual Coding
  - Enhanced Diagnosis Search
  - Visit Screen Enhancements
  - Claim Edit Screen Enhancements
- **Home/Management Dashboard**
  - Manage Dual Coded Claims
  - Dual Coding Review
  - ICD-10 ANSI Generation
- **Patient Demographics**
  - Case Screen Enhancements, primary diagnosis
- **EMR Enhancements**
  - Diagnosis Search
  - EMR Problem List
- **Claims Manager Upgrade**
- **Connection via Standard Interface Engine Flags**
- **Institutional vs Professional Billing**
ICD-10 CM Structure

- 21 Chapters | Approximately 70,000 codes
- Alpha characters are not case sensitive
- 3-7 Alphanumeric characters long and include a decimal after the third character
  - Characters 1-3: Category of disease
    - 1st character is alpha (except for U).
    - 2nd & 3rd characters are numeric.
  - Characters 4-6: Etiology, anatomic site, manifestation, severity and other clinical data; can be alpha or numeric.
  - Character 7: Extension, it provides information about the characteristic of the encounter, it is used in several chapters such as OB, Injury, Musculoskeletal, Causes and Injury and Certain Other Consequences of external causes; can be alpha or numeric.
- Use of dummy placeholder “x” this frequently occurs with poisonings and injuries
  - The letter "x" serves as a placeholder when a code contains fewer than six characters and a seventh character applies, it allows for future expansion.
Tabular List and Index are structured similarly to ICD-9, with a few exceptions

- A few chapters have been restructured
- Eye and Ear sense organs have been separated from the Nervous System chapter and moved to their own chapters
- Injuries are grouped by anatomical site rather than type of injury.
  - Example: Injuries to head (S00-S09) - (ICD-9 classified them as fractures, dislocations, sprains and strains)

7th Character Injuries and External Causes:

- A Initial Encounter
- D Subsequent Encounter
- S Sequela (A secondary consequence or result, a chronic condition that is a complication of an acute condition)
ICD-10 Harris CareTracker Clinical Workflow
- Read a clinically relevant scenario

- Use Harris CareTracker to dual code the scenario, generate a claim and view the dual code report
**Scenario 1**: While chopping vegetables in the kitchen of his mobile home for the local food bank’s Thanksgiving dinner, John Doe lacerated his right thumb causing injury to his nail.

*In the ICD-9 world the coding would look like this, with External Cause codes not a requirement.*

- 883.0 Open wound of finger(s), without mention of complication
- E920.0 Accident caused by knives, swords, and daggers
- E849.0 Place of occurrence, home
- E015.0 Activities involving food preparation and clean up
- E000.2 Volunteer Activity

*Transitioning into the ICD-10 world, the coding would look like this.*

- S61.111A Laceration without foreign body of right thumb with damage to nail, initial encounter
- W26.0XXA Contact with knife, initial encounter
- Y92.020 Kitchen in mobile home as the place of occurrence of the external cause
- Y93.G1 Activity, food preparation and clean up
- Y99.2 Volunteer Activity
**ICD-10 Coding Scenarios**

**Workflow**
- Problems on the Problem List will not be updated to ICD-10.
- You will need to Inactivate the ICD-9 Only Problem
- Add the Correct ICD-10 Code or Codes
- Remember that the codes must be to the highest level of Specificity and Laterality.

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**Open Patient Medical Record from Clinical Today**

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**Problem List**

- **Diagnosis**
  - Type 2 diabetes mellitus without complication
  - Macular Pucker/ing Of Retina
  - Diab W/O Comp Type II/Unc Stated Uncnt

- **ICD Code**
  - 250.00, E11.9
  - 362.56
  - 250.00
  - 784.0
## Future Changes to Problem List

### Current

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Onset Date</th>
<th>Last Diagnosed</th>
<th>Provider</th>
<th>State</th>
<th>Status</th>
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<tbody>
<tr>
<td>Broken leg</td>
<td>827.0</td>
<td>S82.90XA</td>
<td>9/22/2014</td>
<td>9/22/2014</td>
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<tr>
<td>Cough</td>
<td>786.2</td>
<td>R05</td>
<td>9/15/2014</td>
<td>9/15/2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postmeasles Pneumonia</td>
<td>055.1</td>
<td></td>
<td>1/5/2015</td>
<td>1/5/2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Cluster Headache</td>
<td>339.02</td>
<td></td>
<td>1/6/2015</td>
<td>1/6/2015</td>
<td>Best, Wayne W</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angina at rest</td>
<td>413.9</td>
<td>I20.8</td>
<td>3/18/2015</td>
<td>3/18/2015</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Proposed

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9</th>
<th>ICD-10</th>
<th>Onset Date</th>
<th>Last Diagnosed</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Broken leg</td>
<td>027.0</td>
<td>S82.90XA</td>
<td>9/22/2014</td>
<td>9/22/2014</td>
<td></td>
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</tr>
<tr>
<td>Cough</td>
<td>786.2</td>
<td>R05</td>
<td>9/15/2014</td>
<td>9/15/2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td>456.7</td>
<td></td>
<td>1/2/2015</td>
<td>1/2/2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
<td>123.456</td>
<td>1/1/2015</td>
<td>1/1/2015</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ICD-10 Coding Scenarios

Future Changes to Problem List

Current

Proposed

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angina at rest</td>
<td>413.9</td>
<td>123.45Y</td>
</tr>
<tr>
<td>Cough</td>
<td>123.5</td>
<td></td>
</tr>
<tr>
<td>Broken leg</td>
<td></td>
<td>596.3</td>
</tr>
</tbody>
</table>
EMR Enhanced Diagnosis Search

A robust, provider friendly “key word” search was introduced into the EMR that instantly maps ICD-9 to ICD-10 codes. The search will prompt for supplementary classification codes. Throughout the EMR product, the provider can search by the most clinical relevant term and the system will automatically map that to both ICD-9 and ICD-10.
EMR Progress Note
A patient’s problem list can now support both ICD-9 and ICD-10 codes.

The Favorites drop-down list displays both ICD-9 and ICD-10 codes.
EMR Progress Notes

Providers will choose DX based on all aspect of Visit. The DX may be on the DX, A&P or Plan Tab.

Patient been seen today for cut on right thumb.

Patient while chopping vegetables in the kitchen of his mobile home for the local food bank’s Thanksgiving dinner, John Doe lacerated his right thumb causing injury to his nail.

Provider need to code all items that are related to problem
Scenario 2: Jane and John Doe were shopping at the mall the day after Thanksgiving to take advantage of the sales. While rushing for the newest iPhone, John fell down the stairs. Thankfully, John sustained only minor abrasions to his right elbow.

In the ICD-9 world the coding would look like this, with External Cause codes not a requirement.

- 913.0 Elbow, forearm, and wrist, abrasion or friction burn, without mention of infection
- E880.9 Fall on or from stairs or steps
- E849.6 Place of occurrence, public building

Transitioning into the ICD-10 world, the coding would look like this.

- S50.311A Abrasion of right elbow, initial encounter
- W10.9xxA Fall (on) (from) unspecified stairs and steps, initial encounter
- Y92.59 Other trade areas as the place of occurrence of the external cause
Scenario 3: A 6 year old presents with fever and right ear pain. Examination reveals acute right serous otitis media with slight perforation of the central portion of the tympanic membrane. Of note, the patient’s parents are smokers, and the patient is often exposed to cigarette smoke in the home and automobile.

*In the ICD-9 world the coding would look like this, with Supplementary Classification codes not a requirement.*
- 381.01 Acute serous otitis media
- 384.21 Central perforation of tympanic membrane
- V15.89 Other specified personal history presenting hazards to health

*Transitioning into the ICD-10 world, the coding would look like this.*
- H65.01 Acute serous otitis media, right ear
- H72.01 Central perforation of tympanic membrane, right ear
- Z77.22 Contact with and (suspected) exposure to environmental tobacco smoke (acute) (chronic)
Ten rules to follow to get from ICD-9 CM to ICD-10 CM
Understand mappings are translations to facilitate conversion of applications and systems

- Not crosswalks
- Not intended to be a 1:1 code match
- Provide multiple translation alternative choices
- Rules and assumptions applied not readily known
- May not provide complete clinical picture of coded data
- Not intended to be applied to all conversion needs

493.01 Extrinsic asthma with status asthmatic
J45.22 Mild intermittent asthma with acute status asthmaticus
J45.32 Mild persistent asthma with acute status asthmaticus
J45.42 Moderate persistent asthma with acute status asthmaticus
J45.52Serve persistent asthma with acute status asthmaticus
Understand differences in clinical concepts

- ICD-9 CM is inconsistent in terminology and outdated in clinical concepts
- ICD-10 CM includes consistent and updated medical terminology and knowledge, technology advances, and current clinical concepts
- Know limitations of the documentation

493.01 **Extrinsic** asthma with status asthmatic

*J45.22 Mild intermittent* asthma with acute status asthmaticus

*J45.32 Mild persistent* asthma with acute status asthmaticus

*J45.42 Moderate persistent* asthma with acute status asthmaticus

*J45.52 Serve persistent* asthma with acute status asthmaticus

Other fifth-digit options ‘0’ uncomplicated, ‘1’ with (acute) exacerbation
Rule 3

Set decision-making rules

- Many codes translate to clusters (groups) or many codes
- Assess use of data before setting rules
- Decisions must be made as to how to translate, which concept takes priority (reimbursement, clinical, etc.)
- Document assumptions and rules used

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>647.03</td>
<td>Syphilis complicating pregnancy, antepartum</td>
</tr>
<tr>
<td><strong>O98.111</strong></td>
<td>Syphilis complicating pregnancy, first trimester</td>
</tr>
<tr>
<td><strong>O98.112</strong></td>
<td>Syphilis complicating pregnancy, second trimester</td>
</tr>
<tr>
<td><strong>O98.113</strong></td>
<td>Syphilis complicating pregnancy, third trimester</td>
</tr>
<tr>
<td><strong>O98.119</strong></td>
<td>Syphilis complicating pregnancy, unspecified trimester</td>
</tr>
</tbody>
</table>
Define documentation needs

- New clinical concepts residing in ICD-10 CM should be identified and conveyed
- Begin identifying concepts in documentation now to aid in mapping

**S59.001 – Salter-Harris Type I** physeal fracture of lower end of ulna, right arm

**S59.041 – Salter-Harris Type IV** physeal fracture of lower end of ulna, right arm
Understanding the coding guidelines and instructions for each system

- Structure and conventions
- Use additional code instructions
- Application of appropriate guidelines

487.0 Influenza with pneumonia

**Use additional code to identify pneumonia (480.0-480.9, 481, 482.0-482.9...)**

**J12.9 Viral pneumonia, unspecified**

**Code first and associated lung abscess (J85.1)**

In the ICD-10 CM to ICD-9 CM GEM, J12.9 maps to both 487.0 and 480.9

In the ICD-9 CM to ICD019 CM GEM, 487.0 only maps to J12.9
Use mappings bi-directionally

- In some instances, one map may not include a code that is required in coding a condition that is a combination code in one code set or the other.

**ICD-9 CM coding:**
- 038.9 Unspecific septicemia
- 955.92 Severe sepsis
- **785.52 Septic shock**

**ICD-10 CM coding:**
- A41.9 Septicemia, unspecified
- R65.21 Severe sepsis with septic shock

785.52 does not exist in the ICD-9 CM to ICD-10 CM GEM, but maps to R65.21 in the ICD-10 CM to ICD-9 CM GEM.
Pay attention to the ‘attributes’

- Attribute codes in the GEMs indicate type of match (identical/approximate), whether you map to combination or codes or not, indicates how many scenario, and the choice list.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>995.92</td>
<td>Severe sepsis</td>
<td></td>
</tr>
<tr>
<td>R6520</td>
<td>99592</td>
<td>10000</td>
</tr>
<tr>
<td>R6521</td>
<td>99592</td>
<td>10111</td>
</tr>
<tr>
<td>R6521</td>
<td>78552</td>
<td>10112</td>
</tr>
</tbody>
</table>
Identify and resolve issues

- Approximately 95% of the mapping results require no additional review based upon use as reimbursement data
- Review those mappings that have conflict
- Document assumptions and rules in decision making

I09.89 Other specified rheumatic heart disease
   MDC 5 DRGs 314-316

398.99 Other and unspecified rheumatic heart disease
   MDC 5 DRGs 306-307

397.1 Rheumatic diseases of pulmonary valve
Plan for changes

- Until both codes sets are frozen, there will be updates to the mappings
- Develop procedures to review all changes
Remember, GEMs are neither flawless or final

- Become familiar with the code sets, structure, and conventions
- ICD-10 CM is a classification system, so much more than just a set of codes; groups have clinical cohesiveness

- Always use caution
- Review all alternatives provided by GEMs
- Investigate alternatives not provided by the GEMs
- Do not consider GEMs the only tool
- Code cases using the code books then test mapping results
ICD-10 Updates & Enhancements
Reports

ICD-10 Payer List

- Harris CareTracker will flag payers and/or plans as ICD-10 ready when we receive notice that payers/plans are accepting ICD-10 codes.

- This will automatically update the payer/plan as ‘ICD-10 ready’ and restrict the type of code set that can be used when billing to this payer/plan.

- ICD-9 and ICD-10 icons have been added to the application screens to assist end user coding.

- This list is located in Reports/Productivity Reports/Other Reports.

Screen shot of Visit Entry screen with ICD icon to indicate the code set accepted by the patient’s case insurance that is linked to the appointment.
Reports

*Top Diagnosis Codes by Company (not a new report)*

- In preparation for the use of ICD-10 diagnosis codes, we recommend running the Top Diagnosis Codes report.

- This report offers filters by group, date of service & # of “top” codes.

- You could choose, 50, 100, 200 etc.

- Analyzing the results of this report will help the practice determine the types of codes to include on their new encounter form which will pull into the electronic visit entry screens.

- This will also be an important aide in mapping the most common diagnosis codes to the new ICD-10 code set.

- This list is located in Reports/Productivity Reports/Other Reports
# Top Diagnosis Codes by Company (not a new report)

## Top Diagnosis Codes by Company

Objective: The purpose of this report is to show the top 100 ICD-9 Codes by count. (includes ties)

Harris CareTracker Training Company

Date Range: 01/01/2015 - 05/15/2015

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Diagnosis Name</th>
<th>Total Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>784.0</td>
<td>Headache</td>
<td>17</td>
</tr>
<tr>
<td>462</td>
<td>Acute Pharyngitis</td>
<td>8</td>
</tr>
<tr>
<td>250.00</td>
<td>Diab W/O Comp Type II/Uns Not Stated Uncntrl</td>
<td>5</td>
</tr>
<tr>
<td>780.4</td>
<td>Dizziness And Giddiness</td>
<td>4</td>
</tr>
<tr>
<td>785.1</td>
<td>Palpitations</td>
<td>4</td>
</tr>
<tr>
<td>785.51</td>
<td>Precordial Pain</td>
<td>4</td>
</tr>
<tr>
<td>789.00</td>
<td>Abdominal Pain, Unspecified Site</td>
<td>4</td>
</tr>
<tr>
<td>250.10</td>
<td>Diab W/Ketoacidosis Type II/Uns Not Stated Uncntrl</td>
<td>3</td>
</tr>
</tbody>
</table>
Dual Coding

- Dual coding enables the selection of both ICD-9 and ICD-10 codes for all operators in a group. Dual coding gives providers and coders the opportunity to practice billing and selecting ICD-10 codes when coding a charge or visit without disrupting workflow. The system will not generate a claim with both codes.

- The dual coding parameter is a radio button located in Admin/Setup/Group Dx Code Setting. When the parameter is set to “Yes”, the group can add both ICD-9 and ICD-10 codes to a visit or charge. Both the ICD-9 and ICD-10 code versions are sent to ClaimsManager, but only the code version assigned to the case insurance will be sent to the payer.

- Enabling dual coding does not require charges or visits be dually coded. If an operator chooses to dual code, not all procedure lines need to be dual coded; an operator can decide which procedures (if any) to dual code.

- When dual coding is enabled; a patient’s active problem list and ‘Today’s Selected Diagnosis’ coming from the EMR will display both the ICD-9 and ICD-10 code on the visit page.
Administration

Enable Dual Coding - Group Dx Codes Setting Maintenance

This maintenance will allow a practice to enable ‘dual coding’. In addition, an override requiring ICD-9 or ICD-10 for specific insurance companies or plans will enforce that code version during charge or visit entry and send that code version in the electronic or printed claim file. Overrides are most useful in training companies, certain testing scenarios or for providers who have special circumstances as they prepare to switch over to ICD-10 codes.

NOTE: Testing only requires that the Dual Code Entry selection is set to YES. No Insurance should be added to this link for testing purposes.
Administration

New Encounter Form Maintenance

- Support ICD-10 code sets
- Use of ICD ‘groupings’ in encounter form maintenance reduces the # of codes physically listed on the encounter form/visit page

**NOTE:** Old Encounter form maintenance is no longer supported
Electronic Visit Entry / Visit Capture

Harris CareTracker Confidential
Visit Capture Enhanced Dx Search

- The diagnosis search has been enhanced with EncoderPro technology that allows you to see which ICD-10 codes map to the current ICD-9 codes.
- After clicking on a result, an icon at the top of the screen indicates if backwards mapping to either ICD-10 or ICD-9 codes is available.
- The ICD Mapping screen is accessed by clicking the View Mappings link at the top of the search results.
- This screen acts as a basic mapping tool, allowing the operator to see which ICD-10 codes map to the current ICD-9 codes and vice versa.
### Dx Code Mapping

<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
</tr>
</thead>
</table>
| Coding Tips       | This column displays icons to indicate whether the code has single mapping or complex/combo mapping:  
A puzzle icon indicates a complex/combo mapping. Click the icon to display the code alternative combination mapping scenarios that are possible for the corresponding code.  
A star icon indicates that this code is the preferred code for billing purposes. **Note:** This is a suggestion and not a rule. The actual services provided or your billing practice may dictate that a different code may/should be used.  
The GEM map icon indicates that this code is acceptable to be used according to the US government standards.  
The Optum map icon indicates the suggested code to be use according the clinical technical experts at Optum.  
**Note:** If the Coding Tip column is blank, then only simple mapping is available. |
| Code Alt          | Displays alternate codes as hyperlinks                                                                                                                                                                |
| Description       | Displays description of the ICD codes                                                                                                                                                                 |
| Instructional Notes | This column displays icons to further explain the note for the code alternative:  
- White Paper icon: Shows the section of instructional notes for the code. This is for ICD-9-CM codes.  
- Green Paper icon: Show the section notes for the entire section of the book to which the code applies. This is for ICD-10-CM codes.  
- Red Paper icon: Show the category notes for the code's category. This is for ICD-10-CM codes.  
- Yellow Paper icon: Show the chapter notes for the chapter for that code. This is for ICD-10-CM codes. |
| Backward Mapping  | Displays a hyperlinked list of related ICD codes that can be mapped backwards from the corresponding ICD code (ICD-10 to ICD-9 OR ICD-9 to ICD-10). |
Visit/Charge Entry

Dual Coding

Dual Coding Prerequisites

A company must meet the following prerequisites to utilize the Dual Coding Review and generate ICD-10 test claims:

- Companies must be enabled for Dual Coding. Dual coding is enabled in the Administration Module>Setup Tab>Group Dx Code Settings.

- Charges must be dual coded (contain both ICD-9 and ICD-10 codes) to display on the Dual Coding Review work list.

- You cannot generate a claim for the ICD-10 codes until a claim has been generated for the corresponding ICD-9 codes on the charge.

Use of ICD-10 codes during Visit/Charge Entry for testing

Only 1 CPT/Service line needs to include dual ICD-9 and ICD-10 codes for testing.
Visit Entry

Visit Screen Enhancements

An ICD code indicator has been added based on the visit’s insurance to ensure the correct code is being used by the insurance payer/plan flags configured.
Visit Entry

Dual Coding

Only 1 procedure line on the visit needs to have both ICD-9 and ICD-10 codes.
Claim Edit Screen Enhancements

ICD code indicators have been added to ensure the correct code version is being used during claim edits.
Home/Management Dashboard

**Dual Coding Review link**

The Dual Coding Review application allows companies to generate test claims containing both ICD-9 and ICD-10 codes. Operators can then download the test claims for use in payer specific ICD-10 claim testing. The application also allows you to review a history of Claims Manager edits.
The Dual Coding Review Worklist

- This list displays the dual-coded claims and charges for the group in context.
- You can filter the list by a specific provider or insurance for any 7 day service date range.
- Office staff can review dually coded charges, observe coding errors and generate an ANSI file using only the ICD-10 codes which will be useful when testing with payers.
- Selecting the “show claims only” check box, hides charges for which a claim has not been generated.
- This dual coding review work list is located in the Home Module/Dashboard/Management/DualCoding Review tab.

The “Test 837” check box is disabled for charges that do not have an associated claim generated and if the original ICD-9 claim was generated on paper. Select the TEST 837 button at the end of the claim line and click the Generate Test 847 button at the bottom of the window to create an ANSI file for ICD-10 testing. The export/printer option allows the operator to print or save the contents of the work list in a .CSV file.
The Dual Coding Review Worklist

The Dual Coding Review screen displays patient information and coding details. The image highlights a patient named Abbott, Nancy A with a date of 02/06/15 and a code of 95013 with units 1 and ICD-10 code 291.4, 686.11 with OM Edit and CM Log.

Generate Test 037 button is visible in the image.
Test Claims Processing Queue Tab
- The Test Claims Processing Queue displays status and error messages for test claims.
- The processing queue only displays messages for the group in context.

Prepared Test Claims Tab
- The prepared Test Claims tab displays a list of prepared claim files sorted by creation date, newest to oldest.
- You can filter the list to display claims for a specific insurance company.
- Select the claim file to upload to the payer and save locally.
The majority of payers will require the dates of service on the test claims to be >= 10/01/2015. As a result, the dates of service will have to be edited on the ANSI file before submitting a test file prior to 10/1/2015. Claims manager will not allow charges to be entered with a future date of service.

To edit the date of service on the ANSI 837 test file, click on the file to save it locally on your computer. If you've never opened an ANSI file before, you may be prompted to assign a default program. Double-click on the saved claim file and when prompted to choose a program, select Microsoft Word or Notepad.

• Open the file and Control H (find and replace)

• Find what: DTP*472*D8*CCYYMMDD (enter the date of service on the claim)

• Replace with: DTP*472*D8*CCYYMMDD (enter a date of service >= Oct 1, 2015)
Patient Demographics, Case Screen Enhancements
The ICD code indicators will appear in the Dx drop-down lists on the case.
Claims Manager Upgrade
Harris CareTracker uses an ICD-10 ready version of Claims Manager to ensure code scrubbing on both code sets.

Connection via Interface Engine Flags
DFT interfaces, CSV Visit Import, and Browse to SFTP import will accept ICD-9 and ICD-10 code sets.

*Note*: There is an additional code set flag that will be needed for those diagnosis codes that are identical in both code sets (there are approx. 50 of these codes). This flag is only present in DFT files imported by our interface engine. (This is dependent on interface connection of third party). This includes both the VPN (real time) and SFTP (batch) DFT interfaces. Our legacy imports do not currently support this code set flag.

We are encouraging clients using these legacy import applications to upgrade to our Connections module.

Institutional vs Professional ICD-10 Claims
When dual coding claims, Institutional claims will use the ‘to date’ on the claim to determine whether an ICD-9, ICD-10 or both are required.

Professional claims determine the ICD code set based on both the ‘from’ and ‘to’ date.
Institutional Claims

- Validation for Institutional Billing
- When the billing type is **Institutional**, the system will validate the ICD-10 effective date on the insurance against the “Date To” on the procedure:
  - If the “Date To” is before the ICD-10 effective date on the insurance, ICD-9 codes should be used. If ICD-10 codes are entered, the system will alert the operator the wrong Dx code version is being used. The operator may remove or correct the ICD-10 codes or ignore the alert and the system will submit the ICD-10 codes to the payer.
  - If the “Date To” is on or after the ICD-10 effective date on the insurance, ICD-10 codes should be used. If ICD-9 codes are entered, the system will alert the operator the wrong Dx code version is being used. The operator may remove or correct the ICD-9 codes or ignore the alert and the system will submit the ICD-9 codes to the payer.
Professional Claims

• **Validation for Professional Billing**
  • When the billing type is **Professional** the system will validate the ICD-10 effective date on the insurance against the “Date To” and the “Date From” on the procedure:
  • If the “Date To” and “Date From” are before the ICD-10 effective date on the insurance, ICD-9 codes should be used. If 10 codes are entered, the system will alert the operator. The operator may remove or correct the ICD-10 codes or ignore the alert and submit both code versions to the payer.
  • **Note:** if dual coding, the system will ensure all procedure lines have an ICD-9 code and will not alert the end user if a ICD-10 code is entered.
  • If the “Date To” and “Date From” are on or after the ICD-10 effective date on the insurance, ICD-10 codes should be used. If ICD-9 codes are entered, the system will alert the operator. The operator may remove or correct the ICD-9 codes or ignore the alert and submit both code versions to the payer.
  • **Note:** if dual coding, the system will ensure all procedure lines have an ICD-10 code and will not alert the end user if a ICD-9 code is entered.
  • If the “Date From” is before the effective date and “Date To” is on or after the effective date, ICD-9 codes should be used. The system will display an error message instructing the operator to split the ICD-9 and ICD-10 codes into separate charges. The operator can either split the charge or submit both codes to the payer.
ICD-10 Testing

CMS File Format & Validity Testing
Harris CareTracker participated in CMS National ICD-10 File Validity Testing March 3, 2014 through March 7, 2014 of last year. Testing efforts were coordinated by Harris CareTracker with selected clients nationwide. Harris CareTracker submitted claims through our clearinghouse to ensure that the data structure and formatting of the electronic claim files passed successfully. This testing was completed without issue.

CMS End to End Testing
Harris CareTracker’s clearinghouse participated in CMS National ICD-10 End-To-End Testing Week starting January 26, 2015 and ending on January 30, 2015. Several Harris CareTracker providers where selected to participate. Harris CareTracker worked with our clients as they were required to identify patient’s on their schedule and dual code patient charges. Using our application to perform all functions, clients were also required to generate ICD-10 ANSI files that were submitted via our clearinghouse to the Medicare contractor.
Update 3/2/2015: The customers we tested with received electronic remittances back which concluded the roundtrip E2E testing positively.
ICD-10 Testing

CMS End to End Testing Update (posted in News 3/10/15)

Harris CareTracker continues to partner with our clearinghouses to ensure ICD-10 readiness for all states and specialties our platform supports. In April 2015, CMS hosted an end-to-end testing period. Each MAC selected 50 submitters for each MAC Jurisdiction supported to participate in the end-to-end testing. Testers were selected randomly from a list of volunteers to represent a broad cross-section of provider types, claims types, and submitter types. The Harris CareTracker Clearinghouse was selected as a submitter for several MAC jurisdictions for this testing. They have in turn selected end users with the highest claims volumes to use for each MAC jurisdiction testing, several of which are Harris CareTracker end users. We worked with those end users to ensure that they entered the adequate number of ICD-10 claims during this testing period. We will update our ICD-10 Readiness Statement with the results of the April testing cycle once we are notified. The most current version of the Harris CareTracker ICD-10 Readiness Statement is available in Documents > Harris CareTracker > Harris CareTracker > ICD-10 Readiness Statement (CT-17040).

Additional Testing

Harris CareTracker’s clearinghouse notifies us when one of our providers is selected or when they are looking for participants. We are not soliciting any customers looking for E2E testing at this time. However, using the functionality in the system, we encourage you to dual code and generate ICD-10 files which may be loaded directly to some payer sites.
ICD-10 Frequently Asked Questions

1. What updates are being made to existing templates and encounter forms to accommodate ICD-10 codes?

   From the global templates, the ICD-10 codes will be pulled into the progress notes from the encounter. Whichever enhancements made to the visit encounter will also reflect into the progress note. The diagnosis search in the progress note will be using the enhanced Dx search.

2. Will my patient’s problem list automatically be converted from ICD-9 to ICD-10?

   The problem list will not be automatically converted from 9 to 10. Once a practice begins to use ICD-10, then the ICD-10 code will update on the patient’s problem list. Practice will be able to manually update/convert the problem list with access to the enhanced Dx search.

3. How will the system distinguish between the different code sets?

   The ICD code sets will be distinguished by an indicator based upon configuration. Harris CareTracker will identify ICD-10 ready payers/plans and set them to accept 10 codes. If your practice does not wish to send 10 codes to that payer/plan, there will be an override maintenance at the channel partner and company level. The code sets will be identified on the user interface using an icon and alert messaging to prevent the user from selecting the wrong code.
ICD-10 Frequently Asked Questions
4. May encounter forms contain both ICD-9 and ICD-10 codes?
   Yes.

5. Will all my encounter forms need to be rebuilt?
   You may continue to use your existing encounter form but if you would like to include ICD-10 codes on your encounter form; yes your encounter forms will need to be re-built using the new encounter form maintenance.

   Using the new encounter form maintenance there is a ‘grouping’ feature which creates hierarchical grandparent/parent/child relationships. When the encounter form is accessed through the visit screen, the hierarchical groupings appear in a ‘drill-down’. This gives end users the ability to customize their groups and account for the increased number of ICD-10 codes needed.
Office Preparation Checklist

- Encounter Forms / Super bills will need to be updated to reflect ICD-10 codes
- Advanced Beneficiary Notice’s (ABN’s) may need to be updated
- Review payer contracts that have stipulations that cover specific ICD-9 codes that will have to be updated to cover ICD-10, schedule meetings with Provider Reps
- Inpatient contracts can include different payment methods. ICD-10 codes have different levels of impact based on the payment method including:
  - High Impact: Medicare Severity-Diagnosis Related Groups (DRG’s) Transplants
  - Medium Impact: Per diem and per case rate (these can rely on methodologies to determine what reimbursement categories will be used)
  - Low Impact: Capitation agreements are generally not impacted, except for carve outs.
- Engage your Providers and staff in ICD-10 training sessions or seminars. Harris CareTracker will continue to provide release training and offer specific sessions throughout 2015 around building new encounter forms and updating your patient’s problem list.
- Review Clinical Workflow to make sure Patient Problem List are being updated with correct Coding.
- Contact your larger payers to check on the ability to send dual coded test claims.
- Take advantage of rapid release/beta to stay current with the latest ICD-10 functionality
Thank you for attending today’s session!