ICD-10: The Payer Perspective

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ICD-10 Summary

Summary
January 15, 2009 – Department of Health and Human Services (DHHS) published a final rule requiring covered entities (providers, health plans & clearing houses) to comply with new code set regulations for:

International Classification of Diseases, 10th Edition (ICD-10)
- Clinical Modifications (ICD-10-CM) Diagnosis Code Set
- Procedure Coding System (ICD-10-PCS) Inpatient Hospital Procedure Coding System.

DHHS Required Compliance Date: Oct 2013

Note that Payers will need to be code-ready well advance of October 2013 to allow for business process changes, training, contract renewals, and trading partner testing.
ICD–10 Background

**Background**

- ICD diagnosis and procedure codes are one of the fundamental elements of Payer business. Significant changes to the coding structure will have impacts in a majority of business processes and systems and will require significant training and updates to medical policies and contracts.

- Industry analysts and advocacy organizations have prioritized ICD–10 and HIPAA 5010 as the top 2 initiatives for health care organizations’ focus over the next 3 years.

ICD–10 Problem Statement

- **Implementation costs**: Compliance with ICD–10 will require significant upfront IT and Business resources and capital expenditure.

- **Operational costs**: Due to the “Date of Service” implementation requirement, dual support of ICD–9 and ICD–10 will drive significant operation cost increase after implementation in 2013.

- **Challenge**: Payers must identify “opportunities” to mitigate the implementation and operational costs of this mandate.
### Comparison of ICD-9 vs. ICD-10

<table>
<thead>
<tr>
<th></th>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Format</strong></td>
<td>3–5 Characters</td>
<td>3–7 Characters</td>
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<tr>
<td><strong># of Codes</strong></td>
<td>Approx 13,000</td>
<td>Approx 68,000</td>
</tr>
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<td>Limited space</td>
<td>Flexible</td>
</tr>
<tr>
<td><strong>Level of Detail</strong></td>
<td>Minimal</td>
<td>Extensive</td>
</tr>
<tr>
<td><strong>Laterality</strong></td>
<td>Lacking</td>
<td>Present</td>
</tr>
<tr>
<td><strong>Specificity</strong></td>
<td>Limited</td>
<td>Extensive</td>
</tr>
<tr>
<td><strong>Interoperability</strong></td>
<td>US Only</td>
<td>US &amp; Most International</td>
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<table>
<thead>
<tr>
<th></th>
<th>ICD-9-PCS</th>
<th>ICD-10-PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Format</strong></td>
<td>3–4 Numeric Only</td>
<td>7 Alpha-numeric</td>
</tr>
<tr>
<td><strong># of Codes</strong></td>
<td>Approx 3,000</td>
<td>Approx 87,000</td>
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<tr>
<td><strong>Technology</strong></td>
<td>Outdated</td>
<td>Current</td>
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<td><strong>Adding New Codes</strong></td>
<td>Limited Space</td>
<td>Flexible</td>
</tr>
<tr>
<td><strong>Level of Detail</strong></td>
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</tr>
<tr>
<td><strong>Laterality</strong></td>
<td>Lacking</td>
<td>Present</td>
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<tr>
<td><strong>Body Parts Description</strong></td>
<td>Generic</td>
<td>Detailed</td>
</tr>
<tr>
<td><strong>Desc. of Methodology</strong></td>
<td>Lacking</td>
<td>Detailed</td>
</tr>
<tr>
<td><strong>DRG</strong></td>
<td>Limited</td>
<td>Enhanced</td>
</tr>
<tr>
<td><strong>Procedure Definition</strong></td>
<td>Lacking</td>
<td>Precise</td>
</tr>
</tbody>
</table>

### ICD-10-CM/PCS Code Format

**ICD-10-CM**

- **Category**
- **Etiology, anatomic site, severity**
- **Extension**

**ICD-10-PCS**

- **Section**
- **Body Section**
- **Device**
- **Qualifier**
- **Root Operation**
- **Body Part**
- **Approach**
Why ICD-10?

<table>
<thead>
<tr>
<th>ICD-9 Limitations</th>
<th>ICD-10 Advantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Outdated, with limited ability to accommodate new procedures and diagnoses</td>
<td>• Supports value-based purchasing and Medicare’s anti-fraud and abuse activities by accurately defining services and providing specific diagnosis and treatment information</td>
</tr>
<tr>
<td>• Lacks the precision needed for a number of emerging uses such as pay-for-performance and biosurveillance</td>
<td>• Supports comprehensive reporting of quality data</td>
</tr>
<tr>
<td>• Limits the precision of diagnosis-related groups (DRGs)</td>
<td>• Ensures more accurate payments for new procedures, fewer rejected claims, improved disease management, and harmonization of disease monitoring and reporting worldwide</td>
</tr>
<tr>
<td>• Lacks specificity and detail, uses terminology inconsistently, cannot capture new technology, and lacks codes for preventive services</td>
<td>• Allows the United States to compare its data with international data to track the incidence and spread of disease and treatment outcomes</td>
</tr>
<tr>
<td>• Will eventually run out of space, particularly for procedure codes</td>
<td></td>
</tr>
</tbody>
</table>
What ICD-10 Means to The Claim Cycle

START: Claims Intake
Update EDI Systems to accept claims

Renegotiate fee schedules & arrange special provisions for remittance

Successful claim adjudication and storage

Develop new fee schedules in order to price claims

Revise Auth Criteria in order to verify Auth

Select Provider/ Update Edits

Update benefits Logic to determine benefit levels

ICD-10/5010 Impact on Reimbursement Cycle

Adjudication: Understand, train & change coding practices based on ICD-10/5010

Check eligibility

ICD-9-CM (US) *
ICD-10-PCS (US)
ICD-10 (WHO)
ICD-10 (AUS)
ICD-10 (CA)

# of Codes

ICD-9-CM (US) *
ICD-10-PCS (US)
ICD-10 (WHO)
ICD-10 (AUS)
ICD-10 (CA)

* Only 4000 used

World Users

Procedure Codes

100,000
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000

0
11,000
18,000
6,000
87,000
What Are The Anticipated Benefits?

- Supports comprehensive reporting of quality data due to the specificity of data collected
- Improved clinical information for research
- Supports value-based purchasing and antifraud activities by accurately defining services and diagnoses
- Clearer code choices
- Improved disease management
- Clearer reimbursement guidelines
- Ensures more accurate payment of new procedures
- Less requests for medical records
- Ultimately less denials

The ICD–10 Problem

- **ICD–10 requires a more complex business approach than 5010.**
  - HIPAA 5010 changes were specified by the Centers For Medicare and Medicaid Services (CMS) by prescriptive EDI technical specifications. CMS recommended Health Care payer’s use of new and modified HIPAA 5010 data elements.
  - ICD–10, on the other hand, requires Health Care Payers to interpret the new ICD–10 code set and determine how to modify business processes so that efficiencies can be gained to drive organizational value and competitive differentiation.
The ICD-10 Problem

- ICD-10 process changes will ultimately impact all payers, physician practices and hospitals in many areas including:
  - **Medical Management**
    - Medical Policy changes made to align with ICD-10 may impact business process
    - Opportunities: richer code set allows for more focused Care Mgmt & Wellness Programs
  - **Contracting**
    - Updating contracts containing ICD-9 codes & references may impact business process
    - Opportunities: additional detail allows for a more precise pricing structure
  - **Fraud & Abuse**
    - Richer data set available for Fraud & Abuse analytics may impact business processes
    - Opportunities: greater specificity of code sets allows for more automation in reviews

ICD-10 Impact Map

In both Physician and Payer settings ICD-10 represents a major impact to all business and technology areas that utilize medical codes.
ICD–10–CM Diagnosis Code Example

Diagnostic Code Set – Broad Impacts

ICD–10–CM provides 50 different codes for “complications of foreign body accidentally left in body following a procedure,” compared to only one code in ICD–9–CM.

- T81 category for complications due to foreign body show how specific these ICD–10–CM codes are compared to the one general ICD–9–CM.

ICD–10–CM codes describe the actual complication, e.g. perforation, obstruction, adhesions, as well as the actual procedure that had been done that resulted in the foreign body being left behind.

- T81.530, Perforation due to foreign body accidentally left in body following surgical operation
- T81.524, Obstruction due to foreign body accidentally left in body following endoscopic examination
- T81.516, Adhesions due to foreign body accidentally left in body following aspiration, puncture or other catheterization

ICD–10–CM Procedure Code Example

Procedure Code Set – Heavily Impacts Inpatient Procedures

ICD–10–PCS provides dozens of combinations of codes for Coronary Artery Bypass Grafts compared to only 7 codes in ICD–9–CM.

- Specificity of an ICD–10–PCS code compared to the more general ICD–9–CM code
- ICD–9–CM codes 36.14 and 36.16 would be reported for this same procedure
- Each ICD–10–PCS character has a specific meaning, and there is no decimal point used in ICD–10–PCS procedure codes

02100Z4 Bypass, One Coronary Artery to Right Internal Mammary Artery, Open

- 0 stands for the medical–surgical section
- 2 is the heart and great vessels body system
- 1 is the root operation of bypass
- 0 is the body part – one coronary artery
- 0 is the approach, which is open for this case
- Z indicates no device was used
- 8 is a qualifier for right internal mammary artery
Impact Assessment Phase – By Business Areas

- Actuarial
- Underwriting
- Sales and Marketing
- Special Investigations/Fraud and Abuse
- Claims/Encounter Processing
- Customer Service
- Legal
- Government Programs
- Provider Contracting
- Provider Servicing
- EDI
- Internal Audit
- Medical Review
- Case Management
- Care Management
- Pharmacy
- Disease Management
- Population Health Management
- Pre-Certification
- Pre-Authorization
- Appeals
- Medical Policy
- Quality Management
- Analytics

Impact Assessment Phase – By Systems

- Data Storage
- Pricing Systems
- DRG Grouper
- Clinical Bundling Applications
- Claims/Encounter Edits
- Medical Necessity Logic
- Duplicate Claims Identification Systems
- Web Portals
- Actuarial Modeling
- Underwriting Knowledge Bases
- EDI Applications
- Fraud and Abuse Detection Applications
- Prior Authorization Systems
- Predictive Modeling Applications
Impact Assessment Phase – By Trading Partners

- Code Set Vendors
- Application Vendors
- Provider Interfaces
- Delegated Activities (i.e. mental health, disease management, etc)
- Other Health Plans (i.e. subcontractors)

The Mapping Problem

Development of a single “official” mapping between ICD-9 and ICD-10 is a major industry concern:
- Only about 5% of all codes will map accurately 1:1
- All other codes will either lose information or assume information that may not be true
- Imperfect mapping will affect processing and analytics in a way that impacts revenue, costs, risks and relationships
- The level of impact is directly related to the quality of translation
- The anticipated quality of translation is currently an unknown
- GEMs does not provide a definitive match
- There may be multiple translation alternatives for a source system code, all of which are equally plausible
- Some translation projects will require selection of a “best alternative”
What are crosswalks?

- Crosswalks are a translation tool used to assign a code from ICD-9 to the best possible match in ICD-10 (and potentially the reverse as well).
- Crosswalks will be created based on the CMS-created General Equivalency Mapping (GEM) files
  - GEMs are more than crosswalks
  - GEMs are more of 2 way translation dictionaries for diagnosis and procedure codes from which crosswalks will be developed.
  - Interpretation of the GEMs will impact everything from medical necessity to reimbursement.
- The development of a crosswalk ideally should be a temporary measure used for specific purposes.
- Crosswalks should not alter the meaning of a code; rather represent the facts as accurately as possible.
- Creating a crosswalk from “scratch” will incur significant costs.

Crosswalks are not the solution to ICD-10 deployment for the industry, rather a tool to be used in creating the solution.

Mapping

What resources are available to map from ICD-9 to ICD-10 and from ICD-10 to ICD-9?

1. Use the ICD10CM/PCS books or on-line files
2. Use AAPC Free On-Line Code Translator
3. CMS General Equivalence Mappings
General Equivalence Mappings Files

- GEMs – General Equivalence Mappings
  - Coordinated effort spanning several years and involving the National Center for Health Statistics (NCHS), the Centers for Medicare & Medicaid Services (CMS), AHIMA, the American Hospital Association, and 3M Health Information Systems
  - Public domain reference mapping designed to give all sectors of the healthcare industry that use coded data a tool to convert and test systems, link data in long-term clinical studies, develop application-specific mappings, and analyze data collected during the transition period and beyond

Suggestions for mappings use include:

- Designed to convert applications and systems
- Test data during implementation
- “Find and replace” codes or lists of codes
- Link data pre and post implementation
- Analyze current claims data with ICD–9 CM to ICD–10 CM/PCS to determine percentage of 1:1, 1:2, 1:3, etc matches.

- GEMs Files are not meant for coding records!!
## Example ICD-9 to ICD-10 changes

### More than just a crosswalk

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>13,000 Procedure Codes</td>
<td>48,000 Procedure Codes</td>
</tr>
<tr>
<td>3,000 Diagnosis Codes</td>
<td>17,000 Diagnosis Codes</td>
</tr>
</tbody>
</table>

- Angioplasty (procedure codes)
  - 1 code
  - 39.50
  - 047K047
    - Specifying body part, approach and device

- Pressure Ulcer Codes (diagnosis codes)
  - 7 codes
  - 707.00-707.99
    - Show location, but not depth
  - L89.131
    - Specific location, depth, severity, occurrence

- No equivalent ICD-9 Code
  - Indicated through notes and other methods
  - Y71.3
    - Surgical instruments, materials and cardiovascular devices associated with adverse incidents

- Autopsy
  - 89.8
  - No ICD-10 code

### ICD-10 Crosswalk Example

- There may be multiple translation alternatives for a source system code, all of which are equally plausible
- Some translation projects require selection of a "best alternative"

#### Clinical Example

A provider sees a patient in a [subsequent encounter] for a [non-union] of an [open] [fracture] of the [right] [distal] [radius] with [minimal opening] with [minimal tissue damage].

**ICD-9 Code:** 81352 - Other Open Fracture of Distal End of Radius ( Alone)

**ICD-10 Code:** S82271M - Other intra-articular fracture of lower end of right radius, subsequent encounter for open fracture type I or II with nonunion

[Note] For all codes related to fractures of the radius:

- †ICD-9 codes = 32
- †ICD-10 codes = 1731
Why should providers care about payer crosswalks?

- Before technology analysis and design can begin payers must make strategic decisions about the use of the ICD-10 codes
  
  *Without standardization it is likely that affected physicians, facilities and payers will come up with different versions of mappings and crosswalks*
  
- Usage of the ICD-10 codes in a consistent, transparent manner will impact every aspect of the industry from policy, to claim submission to revenue and reporting
  
  *Practice revenue will be dependent on reasonable & appropriate interpretation of the ICD-10 code set*
  
- Without guidance there is potential for multiple versions of mappings across the industry
  
  *Collaboration, standardization, consistency and transparency are key in successful code, data and revenue mapping*

Payer Industry Outreach with AHIP

Requested Actions:

- Standardized Industry Guidelines for Crosswalk Development
- Standardized Industry Guidelines for Implementation Date Issues
- Basic Training & Communication Plan
  
  - AHIP w/ Deloitte developed 9 Webinars on readiness
  - AHIP scheduling intensive educational opportunities at the June Institute and November Business Forum
  - Anticipate a more detailed education & outreach plan as Crosswalk Workgroup & Stakeholder Coalition make progress
- Standardized Set of Basic Fraud and Abuse Edits
  
  - AHIP has a Fraud & Abuse workgroup which is looking at ICD-10 based recommendations
- Other Comments
  
  - AHIP providing strong support on CMS freezing code sets effective October 2011

<table>
<thead>
<tr>
<th>AHIP Sub-Work Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance Issues Sub-Work Group</td>
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<tr>
<td>Acceptance Issues Sub-Work Group</td>
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<tr>
<td>Testing Issues Sub-Work Group</td>
</tr>
<tr>
<td>Communication Issues Sub-Work Group</td>
</tr>
<tr>
<td>Questions for CMS Sub-Work Group</td>
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SEC. 10109. DEVELOPMENT OF STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.

(c) ICD CODING CROSSWALKS.—

(1) ICD–9 TO ICD–10 CROSSWALK.—The Secretary shall task the ICD–9–CM Coordination and Maintenance Committee to convene a meeting, not later than January 1, 2011, to receive input from appropriate stakeholders (including health plans, health care facilities, and clinicians) regarding the crosswalk between the Ninth and Tenth Revisions of the International Classification of Diseases (ICD–9 and ICD–10, respectively) that is posted on the website of the Centers for Medicare & Medicaid Services, and make recommendations about appropriate revisions to such crosswalk.

Includes GEMs, reimbursement mappings & industry crosswalk issues

Below is the AHIP schedule to align with this mandate:

Timeline for AHIP Workgroup Recommendations

<table>
<thead>
<tr>
<th>Project Start</th>
<th>Phase 2 Start</th>
<th>Preliminary Recommendations to CMS</th>
<th>Final Recommendations to CMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2010</td>
<td>Jul 2010</td>
<td>Sep 2010</td>
<td>Dec 2010</td>
</tr>
</tbody>
</table>

Industry Commonalities

- Implementation Date Processing Issues:
  - There is potential for confusion regarding the October 1, 2013 implementation date for ICD–10.
  - Implementation date is driven by the **date of service** of the claim – not date of processing like other HIPAA issues (e.g. NPI)
- ICD–10 Code Freeze:
  - Freezing code set updates is a necessary step.
  - Will allow both the federal government and others to focus their limited resources on the ICD–10 conversion process without the additional cost and complexity of addressing ongoing code set updates at the same time.
- Basic Training and Communication Plan:
  - Establishing adequate training and communication plans will affect all in the industry.
  - Within the provider community:
    - Payers can assist as a resource to identify standardized training opportunities
    - Jointly work to determine what to communicate across the sector.
- Fraud and Abuse Edits:
  - Fraud will always be driven by revenue, and therefore, in a fee for service system, by procedure.
  - As such, diagnoses will be submitted that justify the procedures billed.
  - Use of a set of basic, standardized fraud and abuse edits will benefit the entire industry by addressing overpayments from unintentional coding errors.
- Crosswalks:
  - Avoid numerous crosswalks supporting the move from ICD–9 to ICD–10.
  - Without a standardized industry crosswalk, vendors, payers, and providers will likely develop crosswalks using the data they have available.
  - Development of a standardized industry crosswalk based on the CMS created General Equivalence Mappings (GEMs) will enable reductions in cost, time, complexity and risk associated with ICD–10 implementation.
Payer Vendor Strategy

Vendor Readiness Strategy

- Vendor Options
  - System remediation by the vendor
  - May require a total replacement
  - Strategic thinking required
  - Vendor issue will be bigger than 5010 as more applications are impacted.

Will Providers be Ready?

- Communication, and collaboration must exist between providers and payers.
- Payers must commit to transparency in business processes concerning ICD–10 in order to instill trust within provider communities.
- Payers are dependent on provider readiness.
- Areas of provider impact include:
  - People
  - Processes
  - Technology
ICD–10 and the Physician Practice – What payers know.

- Practitioners will look to specialty societies, medical associations and payers for leadership in areas of:
  - Code comprehension of specialty specific changes
  - Documentation guidance to satisfy medical necessity requirements and increased granularity of the ICD–10 code set
  - Training/Education that is specialty specific
  - Communication of regulations, guidelines and updates
  - Practice Management issues
  - Reimbursement Guidance

- Payers have a unique opportunity to strengthen their presence in the industry and lead an ICD–10 call to action within the medical community

Physician – ICD–10 Impacts

Different types of physicians will experience different impacts:

- Private practice physicians (solo, small group)
- Large physician groups
- Employed & academic physicians (all models)
- Government, Researchers and other types

Physician practices are highly cost sensitive, and are already contending with:

- HIPAA Changes
- ARRA/HITECH Meaningful Use Incentive drivers and penalty avoidance
- e-Prescribing incentives/penalties
- PQRI Incentives & penalties

Bottom line: physicians will have to increase specificity in medical record documentation across all places of service.
Considerations – People

- **Physician:**
  - ICD–10 requires detailed documentation of surgical procedures; more detailed impressions of diagnosis due to increased specificity within ICD–10–CM (laterality, timing, etc), and more time to document.

- **Coding staff:**
  - Will require increased anatomy and surgical procedure knowledge; more time to document
  - Potential increase in coding staff to support transition and minimize productivity losses.

- **Entire practice:**
  - Extensive retraining for physicians, coding and revenue cycle staff
  - Productivity losses should be expected during the initial 3–6 months due to steep learning curve associated with use of ICD–10–CM/PCS

Considerations – Processes

- **Office billing/coding work flow**
  - Increased coding queries to physicians for further documentation

- **Contracting code crosswalks reexamined**
  - Medical management program requirements

- **Prior Authorization/Notification changes**
  - Increased complexity/requirements

- **Billing & Reimbursement Accounting**
  - Analysis and trending by payer, changes in coding and data trends
  - Previous data analysis obsolete
  - Extensive remapping required (i.e. comparing healthcare outcomes from ICD–9 to ICD–10)
  - Develop a plan for monitoring revenue impact and responses
Considerations – Technology

- **Practice Management System**
  - Code field type/size increase to 3 – 7 alphanumeric characters in all applications using ICD codes (including all clinical and financial applications where codes are entered/reported)

- **Redesign System Interfaces**

- **Software Changes**
  - Code editing programs (Example: Encoder) will need to be analyzed, redesigned and tested
  - Recalculation of DRG groupers and case mix indexes – inpatient billing

- **Electronic Data Exchanges**
  - Reporting to federal, state, and other regulatory agencies/authorities will need to be analyzed, redesigned to accommodate new data and tested

Benefits of ICD-10 Implementation – Providers

The ICD-10 transition can result in significant value realization if implementation is planned for success.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>How Achieved</th>
</tr>
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<tbody>
<tr>
<td>• Strategic imperative</td>
<td>• ICD-10 transition should be viewed more broadly than “complying with a government regulation”; it serves as an opportunity to create differentiation and new and incremental value for the organization.</td>
</tr>
<tr>
<td>• Positive impact to Case Mix / Quality Reporting</td>
<td>• More specific diagnosis reporting</td>
</tr>
<tr>
<td></td>
<td>• Case mix adjustments</td>
</tr>
<tr>
<td></td>
<td>• More specific quality monitoring / reporting; e.g., Stent Insertion (specific codes for open vs. subcutaneous stent insertions)</td>
</tr>
<tr>
<td>• Reduced cycle time</td>
<td>• Fewer claim rejections and denials due to non-specific diagnoses</td>
</tr>
<tr>
<td>• Increased throughput</td>
<td>• Fewer requests for clinical information</td>
</tr>
<tr>
<td>• Reduced administrative expense</td>
<td>• Expectations of fewer denials from payers could result in significant reduction of rework / administrative expense for both physicians and payers</td>
</tr>
<tr>
<td>• Positively affect patient / community health</td>
<td>• More specific disease management programs</td>
</tr>
<tr>
<td>• Enhanced reimbursement</td>
<td>• Targeted reimbursement based on revised diagnoses and procedure coding</td>
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</tbody>
</table>
Benefits of ICD-10 Implementation – Payers

- Supports comprehensive reporting of quality data due to the specificity of data collected
- Improved clinical information for research, reporting, and benefit design
- Supports value-based purchasing and anti-fraud activities by accurately defining services and diagnoses
- Clearer code choices equates to more accurate reimbursement
- Improved disease/care/medical management
- Clearer reimbursement guidelines
- More specificity in medical/payment/reimbursement policy and pre-authorization notifications.
- Fewer requests for medical records
- Supports incremental value in medicine – fewer unspecified codes?
- Ultimately fewer denials due to increased granularity and stronger relationships between codes.

QUESTIONS...
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