ICD-10

ICD-10: Are you Ready?

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Introductions

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Objectives

1. Confirm a baseline understanding of ICD-10 and areas of impact, especially for those that have not been an active part of a program or workgroup to date

2. Understand successful ICD-10 program components as well as ideas for each to take back to your organization

3. Understand specific revenue cycle focus areas and key activities to initiate to mitigate risk
Agenda

• ICD-10 Overview / Background
• ICD-10 Key Program Components
• ICD-10 Revenue Cycle Impacts
• ICD-10 Assessing and Managing Risk
ICD-10
General Overview / Background
ICD-10 Background

- 343 days until ICD-10 is here – 10/1/2014
- Applies to all covered entities under HIPAA
- Does not affect CPT coding for OP services and physician services
- One implementation date for all users:
  - Data of service for ambulatory and physician services
  - Date of discharge for hospital claims for inpatient settings
Why ICD-10?

• ICD-9 is over 30 years old
  o Outdated terms
  o Limited in the number of new codes
  o Limited data about patient’s medical conditions and hospital procedures

• Last industrialized nation to adopt ICD-10
ICD-9 vs. ICD-10

More codes = Greater Complexity
Timing of the Change:

**How does it Affect Me?**

Software and user procedures must be able to support simultaneous use of both ICD-9 and ICD-10 for some period of time, maybe indefinitely:

- Some payers do not have to transition to ICD-10 (e.g., Worker’s Comp)
- Rebills and secondary bills done after the effective date may need to use ICD-9
- Reporting activity may require use of ICD-9 indefinitely

<table>
<thead>
<tr>
<th>Patient Care Activity</th>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing and Follow-up Activity</td>
<td>ICD-9</td>
<td>ICD-9??</td>
</tr>
<tr>
<td>Reporting Activity</td>
<td>ICD-9</td>
<td>ICD-10</td>
</tr>
</tbody>
</table>
ICD-10: There’s a code for that?

Problems with the in-laws
Z63.1

Sucked into jet engine
V97.33XD

Burn due to water-skis on fire
V91.07XD

Asphyxiation due to being trapped in a discarded refrigerator, accidental
T71.231D

Fall into bucket of water, causing drowning & submersion
W16.221

Animal-rider injured in collision with trolley
V80.730A

Hair causing external constriction
W49.01XA

Walked into lamppost
W22.02XD

Source: HealthcareFinanceNews.com
Focusing on the Benefits

• Alignment of the US with coding systems worldwide
• Improved ability to track and respond to international public health trends
• Greater coding accuracy and specificity
• Higher quality information for measuring healthcare service quality, safety, and efficiency
• Improved efficiencies and lower costs
• Recognition of advances in medicine and technology
• Space to accommodate future expansion
Enterprise Wide Impact

**Information Systems**
- Broad range of impacted systems
- Coordinated testing of all impacted systems
- Reporting

**Coding**
- Training
- Drop in productivity
- Talent Shortage

**Physicians**
- Documentation Specificity
- Increase in documentation time, coding queries

**Revenue Cycle**
- Increase in denials, inquiries, and claims adjustments
- Payer contract renegotiation
- New authorization processes

**Finance**
- Increase in A/R days
- Impact to cash flow
ICD-10

Key Program Components
Key Program Components

- Program Structure
- Coding
- Documentation
- Reporting & Analytics
- Education & Communication
- Information Systems
- Revenue Cycle
Program Structure

ICD-10 Key Program Components

**ICD-10 Governance Team**

**Coding**
- Coder Education
- Coder Productivity
- Recruitment, retention
- CAC
- Dual Coding
- Ambulatory

**Clinical Documentation**
- Chart Reviews
- Forms
- CDI
- Quality
- Case Management
- Ambulatory

**Reporting Analytics**
- Reports inventory
- Prioritization of remediation
- Change Management
- Ambulatory

**Information Services**
- System upgrades
- Implementations
- Assist with reports remediation
- Testing
- Ambulatory

**Education**
- Physician Education
- Coder Education
- All other learners
- Learning Management
- Ambulatory

**Revenue Cycle**
- Assess workflow impact
- Policies/Procedures
- Payer contracts
- Financial Risk assessments
- KPI's
- Ambulatory
Coder Readiness

Coder Productivity

- 20 – 50% short term impact
- 10% permanent impact

Minimizing Productivity Risk

- Coder Education
  - Pre-requisite and I-10 Specific Courses
  - Dual Coding
- Computer Assisted Coding – consider the short term negative productivity hit with bringing CAC live
- Budgeting for increased coding staff
- Coder Recruitment and Retention Strategies
Clinical Documentation

If documentation does not meet requirements:
• Coders can’t code
• Greater increase in physician queries impacting physician productivity
• Increased A/R days due to slowed claims

Address Increased Documentation Requirements
• Perform chart reviews to identify areas needing improvement
• Implement or enhance your CDI Program
• Forms impact
• Education for all documenters
Reporting & Analytics

General Equivalence Mappings (GEMs):

- Designed for reporting across code sets
- “Attempt to find corresponding...codes between the two codes sets, insofar as this is possible”
- Only 24% of ICD-9 Codes have an exact match to an ICD-10 code

<table>
<thead>
<tr>
<th>ICD-9 Diagnosis Code</th>
<th>ICD-10 Diagnosis Code</th>
</tr>
</thead>
</table>
| 1. 1550 Malignant neoplasm of liver, primary | 1. C220 Liver cell carcinoma  
2. C222 Heptablastoma  
3. C227 Other specified carcinomas of liver  
4. C228 Malignant neoplasm of liver, primary, unspecified as to type |
| 1. 4169 Chronic pulmonary heart disease, unspecified | 1. 279 Pulmonary heart disease, unspecified  
2. I2781 Cor pulmonale (chronic) |
| 1. 53551 Unspecified gastritis and gastroduodenitis, with hemorrhage | 1. K2971 Gastritis, unspecified, with bleeding  
2. K2991 Gastroduodenitis, unspecified, with bleeding |
Reporting & Analytics

• Any report that touches an I-9 code WILL need to be re-written
• Develop an inventory of reports
• Implement change management
• Prioritize remediation of reports
• Education for report writers and report requestors
Information Services

Should be maintaining a roadmap of impacted systems:

- **Phase 1:** Testing Prep (Upgrades, test system prep, unit testing)
- **Phase 2:** End to End Testing

### Information Services ICD-10 Remediation Plan

<table>
<thead>
<tr>
<th>Category</th>
<th>Status</th>
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<tbody>
<tr>
<td>Compliant Systems</td>
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<tr>
<td>Non Compliant Systems</td>
<td></td>
</tr>
<tr>
<td>Total Systems</td>
<td></td>
</tr>
<tr>
<td><strong>Compliant Systems</strong></td>
<td>31</td>
</tr>
<tr>
<td><strong>Non Compliant Systems</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Total Systems</strong></td>
<td>35</td>
</tr>
</tbody>
</table>

**System Remediation Timeline**

- Atlas Labworks
- Cerner Millennium
- ComputerMart
- GE Centricity DMS
- GE Centricity Perioperative Anesthesia
- GE Centricity Perioperative Manager
- GE Centricity RIS-IC
- McKesson Horizon Patient Folder
- McKesson Horizon Home Care
- McKesson Series
- MedAssets
- Midas Plus
- Net Health Systems - WoundExpert
- Occupational Health Research - Systoc
- OptumInsight - eFR
- QS/1 Data Systems - NRx
- Wellsoft
- 3M Coding and Reimbursement System

**ICD-10 Key Program Components**

- Phase 2: Testing Preparation (Test system builds, unit testing, etc.)
- Phase 2: End to End Testing
Education

- Diverse education needs
- Significant effort to develop content
- Consider purchasing content
Education
Timeline considerations

<table>
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<tr>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
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</thead>
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Coder Education
- Physician Education
- CDI Education
- Physician Queries
- Dual Coding
- Nursing, Case Managers
- Physician Office Staff, Community MDs
- Integrated Testing
- Remaining Basic & Clinical Users

10/1/2014
Revenue Cycle

Patient Access
- Referral
- Scheduling
- Pre-Reg
- Insurance Verification
- Pre-cert / Auth.
- Pre-Service Collection

Service Delivery
- Reg. / POS Collection
- Financial Counseling
- CM / UR
- Charge Capture
- Charge Capture
- Coding

Reimbursement Management
- Pre-Bill Edits
- Claim Submission
- Claim Follow-up
- Denial Mgmt
- Transaction Posting
- Payment Review

Key
- High-Med Impact
ICD-10

Impacts to the Revenue Cycle

Initiatives addressing today’s inefficient processes will be key to the readiness of the Revenue Cycle for ICD-10
Patient Access:

Patient Access functions will be touched more significantly than many realize; education and training around authorization and medical necessity will be key.

**Take Action**

- Ensure physician order, scheduling, and registration processes and systems store chief complaints in code format, consistently, with no free text
  - Codes must provide the proper level of specificity
- Establish a strict Scheduling Minimum Data Set (MDS) policy that includes ICD codes **AND** descriptions
- Formalize communication process around missing or incorrect ICD codes (i.e., when an I-10 code is provided but an I-9 code is needed)
- Support staff must be:
  - Trained to understand basic anatomy and physiology
  - Educated on the changes in ICD-10 coding procedures

Communication to physician offices and scheduling departments will increase significantly as physicians and patient access staff get trained on the expanded code set.
Diagnosis codes play a key role in the approval of prior authorization requests; a substantial increase in the number of codes presents multiple challenges for providers and staff.

**Take Action**

- Ensure that support staff receive general ICD-10 training including basic anatomy and physiology.
- Discuss timing and procedure for beginning to authorize dates of service past October 1, 2014.
- Establish an ‘add-on’ policy which limits cases requiring last minute authorizations.
- Create job aids and cheat sheets to help staff track procedures that require authorizations.
- Assemble an “ICD-10 Pre-Cert/Auth Group” to keep up with any changes to payer rules around authorizations.

Due to the increase in code volume, more procedures will require authorization. Providers & payers will have to train their employees on the new procedures (i.e., C-section), which might require prior authorizations.
**Take Action**

- Utilization review staff will need clinical level, GEMS, and ICD-10 education
- Tightly monitor physician documentation to ensure medical necessity, appropriateness of care, and proper authorization is obtained for completed procedures
- Payers will focus more heavily on clinical documentation during the appeals process, therefore CM/UR will be required to get more involved in the denials management process

As payers request more detailed documentation to support diagnosis, Case Management & Utilization Review staff will pay a critical role in the revenue cycle.
Reimbursement: Pre-Bill Edits

Edits within the billing scrubber which reference ICD-9 codes will need to be updated to the appropriate ICD-10 code, but many codes do not have an easy one-to-one match. Given the high number of codes being added, it is likely many new edits will need to be created.

Take Action

- Communicate with payers and your clearinghouse; participate in other forums to understand payer state of readiness
- Establish a plan for functional and integrated testing to ensure claims are interfacing properly with both the billing scrubber and clearinghouse
- Complete staffing analysis to understand implications of increase in billing edits; increase in billing edits may require additional staff or increased automation

Centers of Medicare & Medicaid Services (CMS) predicts claims error rates will reach a high of 6% to 10% in comparison with the average 3% error rate with ICD-9.
Reimbursement:

Implementing a denials management system which takes advantage of automation, collection workflow, and robust reporting will help organizations track and manage the additional volume of denied claims.

**Take Action**

- Develop strategies to drive billing work-in-process (WIP) buckets as low as possible prior to implementation.
- Deploy stratification principles during AR follow-up focus on the right accounts at the right time.
- Consider implementing denials management system to automate denials processing and provide robust reporting.
- Focus on reducing denials and streamlining denials processing as much as possible in advance of October 1, 2014.
- Complete a staffing analysis to understand implications of increased denials.

According to CMS, denial rates could increase by 100% to 200% post-implementation. The turnaround time for claims processing could be extended an additional 10 to 20 days.
Things to think about...

**Which Changes are Temporary versus Permanent?**

- How are my staff impacted by this change?
  - Do we input ICD-9 codes today?
  - Do we input diagnoses that are converted to ICD-9 codes?
  - Is there a lookup or a pick list for admitting diagnosis or chief complaint? What will it look like under ICD-10?

- What systems need to be updated?
- Which processes will need to change?
- Will productivity be impacted?
- Are there policies that are impacted?
- Do we have any forms that have ICD-9 codes?
- Are there cheat sheets utilized in these areas?
- Do we run reports that require us to identify diagnoses or procedures?
ICD-10

Assessing / Managing Risk
Assessing Financial Risk

Risk Identification
- What are the different operational and financial risks that could occur as a result of ICD-10?

Risk Assessment
- What is the magnitude if the risk occurs (severity)?
- What is the likelihood of occurrence?
- What level of control does the organization have to prevent this risk?

Financial Assessment
- Has the industry projected the potential magnitude of impact?
- What are the best metrics we can use to quantify the potential financial impacts?
- What does our organization’s financial impact look like based on real data inputs?
Financial Risk Assessment

- Resources are limited during this time of massive change for organizations.
- Completing a Financial Risk Analysis enables the organization to focus training and improvement efforts to areas of highest potential impact.

Examples from Jvion, LLC.
Key Performance Indicators

Access Management

- Capture the percent of claims requiring medical review by provider, type of claim, and the average turnaround time for each impacted claim
- Consider implementing a robust denials management system to:
  - Track/Monitor authorization denials by denial code, payer, plan code, etc.
  - Communicate denial information to ancillary departments

Reimbursement Management

- Track DNFB associated with coding completed but claim rejected during the billing editing process (e.g. invalid diagnosis code, missing data element, or inaccurate payer designator)
- Track and monitor agings by payer and plan code to understand delays in cash
- Track and monitor AR days by payer and plan code
- Track and monitor clean claim rate

Reimbursement Management

- Track denial by reason code bucket, payer, and plan code
- Implement a monthly Denials Task Force which reviews trends in denials metrics and develops remediation efforts for process breakdowns
- Monitor write-offs for spikes in populations effected by ICD-10
# Example ICD-10 Risk Matrix

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Description</th>
<th>Risk Likelihood</th>
<th>RiskSeverity</th>
<th>Overall Risk Weight</th>
<th>Control Level</th>
<th>Financial Assessment</th>
<th>Financial Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Payer Readiness/Claims Adjudication Delays</td>
<td>5</td>
<td>5</td>
<td>25</td>
<td>5</td>
<td>Cash Delay</td>
<td>Low: $ M, Medium: $ M, High: $ M</td>
</tr>
<tr>
<td>2</td>
<td>Increase in claims denials</td>
<td>4</td>
<td>3</td>
<td>12</td>
<td>4</td>
<td>Denials</td>
<td>Current: $ M, Increase: $ M, Increase: $ M</td>
</tr>
<tr>
<td>3</td>
<td>Unexpected/reduced reimbursement</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>Case Mix</td>
<td>.5% Shift: ($ M), 1% Shift: ($ M), 2% Shift: ($ M)</td>
</tr>
<tr>
<td>4</td>
<td>Increase in payer scrutiny/audits</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>3</td>
<td>Impacted Audit Dollars</td>
<td>Current: $ M, 10% Growth: $ M, 25% Growth: $ M</td>
</tr>
<tr>
<td>5</td>
<td>Impact to quality reporting/incentives</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>Annual Payment Update</td>
<td>(SM), 1% loss of APU</td>
</tr>
<tr>
<td>6</td>
<td>Physician Documentation</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>3</td>
<td>Productivity Impacts</td>
<td>15% decrease: Steady State: 15% increase: $ K, $ K, $ K</td>
</tr>
<tr>
<td>7</td>
<td>Coder Productivity</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>2</td>
<td>Productivity Impacts</td>
<td>Total Staffing Estimates: $ M</td>
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<tr>
<td>8</td>
<td>Coder Readiness</td>
<td>3</td>
<td>5</td>
<td>15</td>
<td>1</td>
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</tr>
<tr>
<td>9</td>
<td>Vendor/Vidant system readiness</td>
<td>1</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

**Legend:**
- **Overall Risk Weight** is calculated by multiplying the likelihood and the severity. The higher the number, the greater the risk.
- **Control Level Description:**
  1 - Essentially avoidable through selected risk mitigation actions
  2 - Highl7y controllable through organization or program actions
  3 - Moderately controllable through organization or program actions
  4 - Largely uncontrollable by the organization or program actions
  5 - Uncontrollable by the organization or program actions
Questions / Open Discussion
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