ICD-10 Triage:
With Eleven Months to Go, What Do You Need To Do?
Assess – Prioritize – Treat

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I. Introduction

II. Triage current state:
- Overview of the process of hospital / physician practice transition to ICD-10, including
  - gathering of all internal resources
  - understanding of timetable requirement
  - milestone planning

III. Take steps to guarantee the continued stability of your environment:
- Review of the internal implementation components of education, training, vendor identification, payor communication, and provider documentation support
- Review of the external requirements and effects of working with community partners and practices in transition to ICD-10
- Identification of strategies for achieving success in implementation, and discussion of specific action steps

IV. Question and Answer Session
It's Not a Secret. Wake Up!

International Classification of Diseases:

ICD - 10

OCTOBER 1, 2014
Executive Summary

Chargemaster

Front End

Back End
Background—Still Needed To Educate

• ICD—International Statistical Classifications of Diseases and Related Health Problems—is overseen and endorsed by the World Health Organization, and is the international standard for diagnosis and classification of epidemiological general health and clinical use.

• ICD-10 is the tenth revision of ICD, completed approximately 1992

• Current version of ICD-10 includes over 68,000 CM codes, compared to 14,000 ICD-9 codes

• ICD procedure codes are controlled by Medicare in consultation with commercial payors. ICD PCS will increase from 4,000 ICD-9 codes to 87,000 and counting in ICD-10

• Few codes directly crosswalk to ICD-9 selections

• Adopted by member states beginning 1994

• US plans to adopt ICD-10 on October 1, 2014

“It is not necessary to change. Survival is not mandatory.”

- W. Edwards Deming
What Are Hospitals Saying?

- Survey after survey illustrate the challenges facilities and physician practices face when implementing ICD-10
- The surveys illustrate a consistent theme
  - The majority of hospitals do not have a:
    - steering committee
    - schedule to govern implementation
    - budget
  - The majority of physician practices do not have a:
    - schedule
    - Budget
    - effective denial management program
- ICD-10 is not something that will be magically implemented
- Each entity must plan for the change and take daily action to ensure its success
CMS Myths and Facts

As the deadline for ICD-10 implementation approaches, CMS is offering increasingly specific information about ICD-10-CM/PCS, including a series of “Myths and Facts.”

**MYTH:** ICD-10-CM/PCS implementation planning should be undertaken with the assumption that the Department of Health and Human Services (HHS) will grant an extension beyond the October 1, 2014, compliance date.

**FACT:** All Health Insurance Portability and Accountability Act (HIPAA)-covered entities must implement the new code sets with dates of service, or date of discharge for inpatients, that occur on or after October 1, 2014. HHS has no plans to extend the compliance date for implementation of ICD-10-CM/PCS; therefore, covered entities should plan to complete the steps required to implement ICD-10-CM/PCS on October 1, 2014.

**MYTH:** Non-covered entities, which are not covered by HIPAA such as Workers’ Compensation and auto insurance companies, that use International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) may choose not to implement ICD-10-CM/PCS.

**FACT:** Because ICD-9-CM will no longer be maintained after ICD-10-CM/PCS is implemented, it is in non-covered entities’ best interest to use the new coding system. The increased detail in ICD-10-CM/PCS is of significant value to non-covered entities. The Centers for Medicare & Medicaid Services (CMS) will work with non-covered entities to encourage their use of ICD-10-CM/PCS.

Source: CMS Medicare Learning Network ICD-10 Myths and Facts
CMS Myths and Facts

**MYTH**: State Medicaid Programs will not be required to update their systems to use ICD-10-CM/PCS codes.

**FACT**: HIPAA requires the development of one official list of national medical code sets. CMS will work with State Medicaid Programs to ensure that ICD-10-CM/PCS is implemented on time.

**MYTH**: The increased number of codes in ICD-10-CM/PCS will make the new coding system impossible to use.

**FACT**: Just as an increase in the number of words in a dictionary doesn’t make it more difficult to use, the greater number of codes in ICD-10-CM/PCS doesn’t necessarily make it more complex to use. In fact, the greater number of codes in ICD-10-CM/PCS make it easier for you to find the right code. In addition, just as you don’t have to search the entire list of ICD-9-CM codes for the proper code, you also don’t have to conduct searches of the entire list of ICD-10-CM/PCS codes. The Alphabetic Index and electronic coding tools are available to help you select the proper code. It is anticipated that the improved structure and specificity of ICD-10-CM/PCS will assist in developing increasingly sophisticated electronic coding tools that will help you more quickly select codes. Because ICD-10-CM/PCS is much more specific, is more clinically accurate, and uses a more logical structure, it is much easier to use than ICD-9-CM. Most physician practices use a relatively small number of Diagnosis Codes that are generally related to a specific type of specialty.

**MYTH**: ICD-10-CM/PCS was developed without clinical input.

**FACT**: The development of ICD-10-CM/PCS involved significant clinical input. A number of medical specialty societies contributed to the development of the coding systems.

Source: CMS Medicare Learning Network ICD-10 Myths and Facts
CMS Myths and Facts

**MYTH:** No hard copy ICD-10-CM and ICD-10-PCS code books will be available. When ICD-10-CM/PCS is implemented, all coding will need to be performed electronically.

**FACT:** ICD-10-CM and ICD-10-PCS code books are already available and are a manageable size (one publisher’s book is two inches thick). The use of ICD-10-CM/PCS is not predicated on the use of electronic hardware and software.

**MYTH:** ICD-10-CM/PCS was developed a number of years ago, so it is probably already out of date.

**FACT:** Prior to the implementation of the partial code freeze, ICD-10-CM/PCS codes had been updated annually since their original development to keep pace with advances in medicine and technology and changes in the health care environment. The ICD-9-CM Coordination and Maintenance Committee implemented a partial freeze where only codes capturing new technologies and new diseases would be added to ICD-9-CM and ICD-10. The code freeze resulted in the following updates:

- On October 1, 2011, the last regular, annual updates were made to both code sets;
- On October 1, 2012, and October 1, 2013, only limited code updates for new technologies and new diseases will be made to both code sets as required by Section 503(a) of Public Law 108-173;
- On October 1, 2014, only limited code updates for new technologies and new diseases will be made to the ICD-10 code sets to capture new technologies and diseases. No further updates will be made to ICD-9-CM on or after October 1, 2014, as it will no longer be used for reporting; and
- On October 1, 2015, regular updates to ICD-10 will resume.

Source: CMS Medicare Learning Network ICD-10 Myths and Facts
CMS Myths and Facts

**MYTH:** Unnecessarily detailed medical record documentation will be required when ICD-10-CM/PCS is implemented.

**FACT:** As with ICD-9-CM, ICD-10-CM/PCS codes should be based on medical record documentation. While documentation supporting accurate and specific codes will result in higher-quality data, nonspecific codes are still available for use when documentation doesn’t support a higher level of specificity. As demonstrated by the American Hospital Association/American Health Information Management Association field testing study, much of the detail contained in ICD-10-CM is already in medical record documentation, but is not currently needed for ICD-9-CM coding.

**MYTH:** ICD-10-CM-based super bills will be too long or too complex to be of much use.

**FACT:** Practices may continue to create super bills that contain the most common Diagnosis Codes used in their practice. ICD-10-CM-based super bills will not necessarily be longer or more complex than ICD-9-CM-based super bills. Neither currently-used super bills nor ICD-10-CM-based super bills provide all possible code options for many conditions. The super bill conversion process includes:

- Conducting a review that includes removing rarely used codes; and
- Crosswalking common codes from ICD-9-CM to ICD-10-CM, which can be accomplished by looking up codes in the ICD-10-CM code book or using the General Equivalence Mappings (GEMs).

Source: CMS Medicare Learning Network ICD-10 Myths and Facts
MYTH: The GEMs were developed to provide help in coding medical records.

FACT: The GEMs were not developed to provide help in coding medical records. Code books are used for this purpose. Mapping is not the same as coding as:

- Mapping links concepts in two code sets without consideration of patient medical record information; and
- Coding involves the assignment of the most appropriate code based on medical record documentation and applicable coding rules/guidelines.

The GEMs can be used to convert the following databases from ICD-9-CM to ICD-10-CM/PCS:

- Payment systems;
- Payment and coverage edits;
- Risk adjustment logic;
- Quality measures; and
- A variety of research applications involving trend data.

MYTH: Each payer will be required to develop their own mappings between ICD-9-CM and ICD-10-CM/PCS as the GEMs developed by CMS and the Centers for Disease Control and Prevention (CDC) are for Medicare use only.

FACT: The GEMs are a crosswalk tool that was developed by CMS and CDC for the use of all providers, payers, and data users. The mappings are free of charge and are in the public domain.

Source: CMS Medicare Learning Network ICD-10 Myths and Facts
Plan for the Change

• To ensure successful implementation each entity must:
  • Assess where you stand today
  • Prioritize next steps
  • Treat the areas of concerns
• ICD-10 implementation will affect every aspect of the patient/provider/facility encounter
• Implementation will require system changes, extensive training and considerable expense
• Likely to impact cash flow during implementation and transition period
• Implementation teams should include senior management and department leadership
Assess—Prioritize—Treat

• Each facility must focus on the following steps to ensure a successful ICD-10 implementation
  • Understand Your Current Situation
  • Gain Administrative Support
  • Implement and Empower Your ICD-10 Steering Committee
  • Communicate
  • Vendor Concerns
  • Business Office / Payer Concerns
  • Physician Practices
  • Implement Employee Surveys
  • Set Your Schedule / Time Table
  • Create Reporting Methodologies / Control Mechanisms
Understand Your Current Standing

• This is your opportunity to set the stage for success
• Be honest
• Have you started your implementation? If not, why?
• What has gotten in the way?
  • Lack of administrative support
  • Lack of intensity / importance
• If you have started, are you as far along as you would hope?
• Who owns the process thus far?
• Regardless of your progress, steady controlled action is the key
  • Identify internal strengths and weaknesses
  • Identify external concerns
• Honest assessment is critical
Understand Your Current Standing

- Every area within your facility or practice will be affected
- Initial assessment should include queries to:
  - All patient servicing departments
  - Case Management
  - Utilization Review
  - Finance
  - Research
  - External business partners
  - Financial Counseling
  - Managed Care, contracting, referral management
  - Admissions and/or Registration team responsible for Pre-Authorization process
  - All business office team members
  - Outpatient Pharmacy
  - Central Supply
  - Human Resources
Understand Your Current Standing

- Create surveys
  - Who has heard of ICD-10?
  - What does ICD-10 mean to the position surveyed?
  - Does the job require the use of diagnosis codes or diagnosis information?
  - In what way?
- Determine current-state average time per patient to:
  - Dictate
  - Enter services (paper super bill or EMR [Electronic Medical Records])
  - Obtain authorization/scheduling of specialty services
  - Code
  - Enter charges into billing system
  - Bill (review claim checks, clearing house flagged claims, etc.)
  - Evaluate and post remit
  - Perform follow up and appeals
  - Provide customer service
Administrative Support

- Successful ICD-10 implementation will only succeed with full CEO/CFO support
- Does your administration understand what ICD-10 implementation represents?
- Do they think that ICD-10 is a “coding issue”?
- Does administration understand that an unsuccessful implementation will challenge the facility’s financial viability?
- Successful implementation is based on the ability of administration to control the process
- Has administration begun the process of educating the board?
- Administration must:
  - control participation in the process
  - set ICD-10 as a priority
  - provide ongoing support to implementation teams
  - understand that this effort is in addition to everyone’s day job
  - set expectations
Steering Committee

• Does your facility or practice have a representative committee to govern the implementation of ICD-10?
• If yes, congratulations! If not, why?
• Aside from administrative support, the ICD-10 Steering Committee is critical to project success
• Team must include
  • HIM (Health Information Management)
  • IS (Information Systems)
  • Professional Coding
  • Business Office
  • Finance
  • Senior Management
Steering Committee

• If you have a committee, how often does it meet?
  • Monthly
  • Weekly
  • Not at all

• Successful Steering Committees have several characteristics:
  • Active participation
  • Regular meetings
  • Assigns responsibility for actionable steps and holds participants accountable
  • Keeps minutes and provides those to administration and board
Steering Committee

• The Steering Committee is ultimately responsible for organizing the team’s approach and mapping out the implementation effort
• Each team member will likely lead smaller teams in independent tracks toward the common goal
• The committee ensures that:
  • all areas are represented
  • the implementation schedule is fair and obtainable
  • the implementation effort is viewed as an opportunity
  • ownership and accountability are instilled with the process
  • inaction and status quo are avoided
  • all schedule points are maintained or rescheduled based on committee agreement
• The steering committee must find ways to counterbalance the “I’m too busy” excuse
Communication

- The steering committee must develop a cohesive message.
- The Facility Implementation Team must speak with one message to departments, coders, payors, vendors, and the community.
- The Implementation Team must immediately develop a mission statement and a unified message.
- Communication of the message must be comprehensive throughout all teams and processes.
- Initial communication must come from the CEO / CFO.
- Initial communication identifies:
  - the importance of the implementation effort.
  - the role of every employee.
  - steering committee members and responsibilities.
  - the potential financial risk to the facility.
  - opportunities for revenue cycle improvements.
Communication

• The steering committee should establish a platform for communicating to every employee
• Use all potential vehicles for communication:
  • Newsletters
  • Mandatory education
  • Public area message boards
• The steering committee must also decide how to communicate to external partners
  • Community physician practices
  • Contracted physician leadership
  • ASC centers
  • Rehabilitation partners
Vendor Technology Assessment

- Technology is the first major domino that must fall for successful implementation
- Every system must be identified
- Every vendor must be contacted
- The steering committee should have one complete list that identifies all vendors, version numbers, and contact information for every system employed within the facility
- Vendors need to provide specific readiness dates
- “Sometime in Q2 2014” is not acceptable
- The steering committee must take responses and place them into the implementation schedule
- Vendor readiness controls integrated testing
Vendor Technology Assessment

- Identify and quantify system needs, current state, and ICD-10 preparedness
- Programs affected--IS should work with departments to develop a comprehensive list of all technologies that could be affected
  - Billing System
  - Medical Record System, including community providers where EMR is accessible to/from facility
  - Clearinghouses (scrubbers)
  - Denial management
  - RIS (Radiology Information Systems), HIS etc.
  - Case Management clinical decision support software (InterQual)
  - Payor’s Preauthorization and PreCert processes
  - Quality reporting and meaningful use reporting
  - All others
Vendor Technology: Vendor Readiness

- All vendors must be contacted to determine
  - Do diagnoses factor into the vendor process?
    - What they need to do to prepare?
    - How will the vendor handle the dual system required during the transition period?
  - What customer support is available?
  - What are the individual vendor timelines for readiness?
  - What, if any, costs to the facility are associated with preparation and implementation?
  - What training will be offered?
  - When will vendor be ready to test?
  - How will testing be scheduled?
Vendor Technology: Vendor Integration and Access

- Systems with no expected changes to accommodate ICD-10 must be evaluated for integration with systems that expect changes.
- Will changes to RIS, Pharmacy, OR modules, etc., affect integrated inventory control or scheduling?
- Who will have access to PHI during testing and implementation plan?
- How will access to sensitive data be protected throughout testing, implementation and integration?
Business Office: Preparedness

• Successful implementation will be monitored through the activities of your business office

• What controls are currently in place to monitor:
  • File size for claim submission
  • Scrubber success rates
  • Payor success rates
  • Late charge submission
  • Business Office knowledge
  • Denial percentages

• The business office may measure the above but not report

• Administration must challenge the business office to establish best practices

• The business office must focus on their internal foundation before communicating with external partners
Business Office Payor Preparedness

- Business Office, IS and Finance must query Payors
- How will claim logic handle dual reporting period?
- How will preauthorization be addressed during the dual reporting period, or cross-over period?
- What training will be offered?
- When will system updates be available for testing?
- What is the expected impact on payment schedule, claim processing?
- Can dual paper/electronic process be accommodated if necessary during transition?
- How will a paper process affect payment schedule?
- Medical Policies affected by changes
  - When will Medical Policies be updated and available for review and training?
  - How will Medical Policies identify and explain dual process periods?
  - How will referral, pre-authorization, etc. be evaluated during cross-over periods?
Business Office: Payor Preparedness

• How is payor integration with clearinghouses COB, non-HIPAA providers, authorization vendors, etc. being tested?
• How will claims be processed when authorization was received for ICD-9 and service was performed with ICD-10 codes?
• What, if any, costs to the facility will be related to this upgrade?
• Will any other upgrades be included in their ICD-10 upgrade?
• What is the intent of non-HIPAA partners?
• Examine the internal risk for MVA / WC claims:
  • Orthopedics
  • Pain
  • Emergency Room volume for slips, falls, motor vehicle incidents...
Business Office—Denial Management

- Examine the impact of increased denials
  - Does your facility / physician practice have a denial management program?
  - What is your current denial rate?
  - What is the financial impact of denials?
  - Is it appropriate, or do you have a denial problem?
  - Is your business office trained appropriately?
  - Do you use your billing system to distinguish between denials by payor?
  - Who owns your hospital denials?
  - Are your physician practices accountable?
Physician Practices

• Physician practice readiness is critical to hospital and physician practice success
• Does the facility understand the importance of correct physician coding / documentation for:
  • Ancillary orders
  • Operative cases
  • Physician practice financial viability
• Physician practices offer specific training challenges
• Readiness is dependent on clinical staff, nursing, coding and front desk training
• The “I’m too busy” excuse is based in reality
• The Steering Committee must overcome the challenge and adapt a response
Physician Practices

- What is the expected impact to productivity?
- Does productivity get measured now?
- Training and education will require a modification to current process
- Schedule blocks will need to be adjusted to accommodate training for Professional providers, therapists, technicians
  - Training in ICD-10 – clinical documentation
  - Training in policy, procedure, protocol changes
  - Training in software changes
- Proper coverage in 24/7 operations will require modification during training to meet medical need and emergent need
- Overtime requirements for training of non-service providers must be examined
  - Coders, Billers, Case Management, UR (Utilization Review), Business Office, IS
Physician Practices

- Examine the impact on departmental and physician productivity
  - Will the physician practices reduce their schedules for a period of time?
  - If so, what is the impact to:
    - Physician gross revenue
    - Ancillary physician revenue
      - Clinic procedures, ancillary lab or radiology revenue, operating room cases
    - Ancillary hospital revenue
      - Lab, radiology, rehab services, OR cases
  - Will hospital services reduce their schedules?
  - What is the impact of lower lab, radiology, or elective OR cases?
  - When will you increase production back to current rates?
  - What is your fallback plan in case of complications?
Employee Surveys

- Create surveys to assess overall employee readiness
  - Who has heard of ICD-10?
  - What does ICD-10 mean to the position surveyed?
  - Does the job require the use of diagnosis codes or diagnosis information?
  - If so, how?
- Surveys focus on all employees and how they interact with ICD-9 diagnosis codes, procedure codes and documentation
- Examine areas such as:
  - Are coders providing all diagnosis codes?
    - Have coders been ICD-10 trained?
    - Are they crosswalking a representative sample of clams to ICD-10 to maintain proficiency and assess provider readiness?
  - Have physicians and other practitioners been ICD-10 trained?
    - Are they receiving feedback from coders on documentation readiness?
  - Does physician/practitioner documentation even meet the ICD-9 requirements?
  - Does the BO understand their role in ICD-10 preparedness?
Employee Surveys

• The surveys will ensure that no one is forgotten
• They will also assist in identifying the training and education necessary for successful implementation
• Identify personnel training required including
  • Professional staff
  • Nursing
  • Technicians, therapists, counselors
  • Case Management, Utilization Review
  • HIM and professional coders
  • Managed Care, Pre-Authorization, Pre-cert staff
  • Business Office
  • Customer Service
  • Financial Counselors
Employee Surveys

- Employee surveys will identify hard and soft dollar impact to the budget
- What is the cost of upgrades?
- What is the cost of training?
  - Classes
  - Course material
  - Lost time
  - Schedule reductions for training, implementation
  - Expansion of hours to accommodate training time
  - Rework time and effort
- What is the projected impact on cash flow?
- What is expected increase in denials / reimbursement?
Employee Surveys

- Use the surveys to identify policies and protocols used by staff during their day-to-day responsibilities
- The survey will assist in the identification of all internal policies, procedures and protocols that will be affected by ICD-10 implementation
- Then responses will allow the steering committee to assign team to evaluate and update
- These updates will take time and resources
- The Steering Committee must establish priorities and timelines
Set the Schedule

• The Steering Committee should immediately establish a schedule to govern the successful implementation of ICD-10
• The schedule should govern activity through March 2015
• The schedule should clearly designate activity by month and by area
• At a minimum, the following areas should be included:
  • Administration
  • Coding
  • Technology
  • Business Office
  • Physician Practice
• The areas should be representative of Steering Committee participation
• The schedule should be placed on a shared drive for real time access
• All steering committee meetings should focus on schedule components
• The schedule allows for increased ownership and accountability
Set the Schedule

- Immediately the facility should represent the following in the project schedule:
  - Appoint an ICD-10 Steering Committee, identify key stakeholders
  - Establish a cohesive message and communication method
  - Identify and prioritize affected systems, areas, and personnel
  - Identify all areas and systems that assign, utilize, or store diagnosis codes
  - Identify all vendors, contractors, business partners that utilize diagnosis codes
  - Identify all policies, protocols etc. that utilize diagnosis codes, or require and understanding of diagnosis codes for proper adherence
- Determine area specific needs
  - Resources
  - Technology
  - Training
  - Expenses
Set the Schedule

• The schedule allows the steering committee to take control of the process
• Daily action is the key
• Without a schedule / timeline the task is too big and widespread
• Eat the elephant one bite at a time
• The facility must:
  • Commit to a timeline
  • Begin financial discovery processes
  • Create a meeting schedule
  • **Stick to the schedule**
  • Create a checklist
  • **Stick to the checklist**
  • Create a timeline
  • **Stick to the timeline**
Reporting Methodologies

• The Steering Committee must establish a set of dashboard controls to eliminate and identify process variability

• The dashboard controls should include areas such as:
  • Gross revenue submission by department by day
  • Late Charge detail by department
  • Electronic File generation size by day
  • Scrubber and payor submission success rate
  • Unbilled accounts by functional area
  • Aged receivable by payor
  • Denial receipt by payor by day

• Many of the above are collected on an informal basis today

• The Steering Committee needs to ensure that historical data is collected and formally reported

• This process needs to start today

• Expectations for reports should be specified in the implementation schedule
Thank you!

Questions?

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