ICD-10 Readiness – 45 Days Until Implementation

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Agenda

- Overview of current state
- Quick review of ICD-10 basics
  - Who, What, When, Why, How
- Steps to ensure you are fully engaged in preparedness and nearing ICD-10 readiness
  - Governance
  - Impact Assessment(s)
  - Project Implementation Management Plan
  - Reduction of AR and build-up of cash on hand
  - Vendor / system readiness
  - Testing
  - Education Plan

What Is ICD-10?

- ICD-10 is the updated version of the ICD-9 codes:
  - Diagnoses for all providers (ICD-10-CM)
  - Inpatient hospital procedures (ICD-10-PCS)
  - In addition to coding – ICD-10 in the US will determine reimbursement!
- ICD-10-CM originated with the World Health Organization (WHO).
- Several countries have taken this code set and modified it for use in their medical systems.
- The US, through the National Center for Health Statistics, has developed the ICD-10-CM (or clinical modification) of the code set for use in this country.
- The Centers for Medicare and Medicaid Services has created a new code set, ICD-10-PCS, for use with hospital inpatients.
- These code sets are considered classification code sets.

Where Are We Now?

- ICD-9-CM and PCS required for use in transactions
  - Diagnoses
  - Inpatient Hospital Procedures
- ICD-9-CM has been in use since 1979
- Required since October 2003 by HIPAA
  - required by HIPAA to use a standard code set to indicate diagnoses and procedures on transactions.
- For diagnoses, we use the ICD-9-CM code set.
- For inpatient hospital procedures, we use the ICD-9-CM procedure code set.
- For other types of procedures, we use CPT or HCPCS codes.
- We will be discussing the soon-to-be required ICD-10-CM codes for diagnoses, and ICD-10-PCS codes for inpatient hospital procedures.
- There are no plans to radically change the CPT or HCPCS Level II code sets at this time.

ICD-10 a Call to Action

Now is the time to prepare for ICD-10!

- **The differences are critical – *not just another coding change*.**
- **Define facility or practice specific needs and PLAN**
- **Assessment will provide outline for achievement of goals**
- **Prepare tasks / activities for implementation**
  - **Designate "owner" for completion of all required tasks**
  - **Staff members, payors, vendors, physicians**
- ***Lead!***
- **Manage progress, and "re-group" when necessary**
- **Reach ICD-10 "readiness" by September 1, 2015!**
- **Use next 6 weeks to reduce AR and ensure positive cash flow.**
- **Use September 1 – 30, 2015, for "contingency" planning**

Why Make the Change to ICD-10?

- **The ICD-10 code set**
  - **–Is much better at describing the current practice of medicine**
  - **–Uses today's medical terminology**
  - **–Has the flexibility to adapt as medicine changes**
  - **–Allows for code set expansion to introduce new diagnoses and procedures as medicine continues to evolve**
  - **–Allows us to compare our data on an international level (since most other developed countries are already using ICD-10-CM)**
  - ***–However – the code set allows for much more specificity for payors to delineate "medically necessary" diagnoses!***

Major Changes from ICD-9 to ICD-10

- Requires changes to almost all **clinical and administrative systems**
- Requires changes to **patient care processes and staff member work flows**
- The updated code sets will allow, and in fact will require, significant changes in the way **services are reimbursed, and in the way that coverage (medical necessity) is determined.**
  - National Coverage Determinants (NCD's) on CMS web-site, and Local Coverage Determinants (LCD's) on CAHABA's web-site.
- Will enable significant improvements in patient care management, public health reporting, research, and quality measurement

Why Make the Change to ICD-10?

- There is an increased emphasis on the use of reported medical information for a multitude of tasks. We (CMS) look to manage individual care, to place patients in special targeted programs, to track population disease patterns, and to identify biological threats.
- We (CMS) are changing the way we look at providers, attempting to measure not only cost of care, but quality of care in an attempt to manage health care expenditures.
- Payors are asking providers to justify increasing health care costs by showing improved outcomes and improved health of patient populations.
  - ICD-10-CM/PCS allows for greater transparency to satisfy all of our reporting requirements and scrutiny outlined above.

Revenue Cycle Processes Impacted

- Scheduling
- Eligibility Verification
- Admitting / Registration
- Financial Counseling
- Utilization Management
- Health Information Management
- Patient Financial Services (pre-bill edits, payments, claims status follow up, etc)
  - Cash collections
  - Percentage of cash collected to charge amounts (revenue)
  - Rejections / denials of services based on diagnoses
- Coordination of Benefits

Clinical Processes Impacted

- **Systems used to document clinical findings will be modified or replaced to accommodate new coding language**
- **Any treating provider who documents in your legal medical record will be impacted, required to document to the highest degree of specificity.**
- **Any treating provider who refers to your facility will be impacted, required to document to the highest degree of specificity for all orders and referrals**
  - **Failure to receive specific documentation (narrative diagnoses) will result in costly rework, denied covered services, and delays in care.**

Consider the "Consequences"!

- **Claims for all outpatient and physician services, and hospital inpatient procedures provided on or after October 1, 2015, must use ICD-10-CM diagnosis and inpatient procedure (ICD-10-PCS) codes.**

  Claims that do not use ICD-10 diagnosis and inpatient procedure codes cannot be processed and paid!

- **It is important to note, however, that claims for services and inpatient procedures provided before October 1, 2015, must use ICD-9 codes even if they are submitted after the compliance date.**
- **Ensure all outstanding accounts are worked, appropriately coded under ICD-9; and resolved prior to September 1st.**
- **Consider the need to start dual coding ICD-9 and ICD-10 in June - July 2015.**

Consider the "Consequences"!

ICD-10 cash flow tips for providers

Financial Management
"ICD-9 has been in use since the late 1970s and while there will be significant long term benefits of migrating to ICD-10, there will also be a higher percentage of rejected claims which will impact cash flow. Now is the time to begin planning for these disruptions and develop strategies to effectively minimize their impact to your organization."

With ICD-10 policies going into effect in 2015, it is critical to understand and prepare for potential cash flow delays, in addition to reviewing other processes you have in place that may be impacted by these changes.

Establish Governance Committee

- Project Management
- Impact Assessments
- Information Systems – Internal and External
- Documentation Improvement Needs
- Process Flows / Job Role Tasks
- Education Needs
- Gap Analysis and Contingency Plan(s)

Project Management

Governance = Management Plan

- **Develop ICD-10 implementation strategy and oversee implementation process (this committee is responsible for overseeing all of the steps in the ICD-10 transition process, but may designate other individuals to complete specific tasks).**
  - **Interviews, Surveys, Facility Walkthroughs**
  - **Documentation Reviews, IT System inventory and reviews**
- **Formulate transition strategies and identify goals.**
- **Develop organization's ICD-10 implementation strategy and identify actions, persons responsible, and deadlines for the various tasks required to complete the transition.**
- **Develop communication plan for staff members, business associates and other internal and external entities.**

Project Management

Timeline

- Conduct Impact Assessment
- Send out initial awareness communication to all staff members, including physicians
- Steering Committee meeting for discussion of assessment results, and to develop mangement action plan(s)
- Bi-weekly meetings / conference calls with Steering Committee to assess progress of action plan.
- Scheduled (date specific) educational sessions with affected staff members identified by job role / position / duties
- Conduct dual coding chart reviews June – July with continual coder education. Share findings!
- *Gap Analysis to be performed prior to September 1st.*

Impact to Your Organization?

- Greatest organizational impact may be to **productivity** –
  - Physician
  - Other Providers, including therapists
  - Patient Access (Registration and Scheduling)
  - Patient Care Management
  - Coding
  - Billing and Collections
- **Consider possible reduction in cash receipts which may impact expense payment for business continuity**

Identify Knowledge Gaps – Staffing Needs

- Evaluate workforce knowledge . . .
- Plan for overtime or requesting PRN / part-time employees to be on call for additional hours of work
- Consider cross-training for rotating job roles for increased productivity during heightened needs
- Temporary, contract and/or outsourced staffing to assist with increased work resulting from the transition, such as coding / billing backlogs, IT support, or coding accuracy review
  - Consulting services to assist with transition
  - Report redesign (and development of new reports)
  - Reprinting of paper forms

Selective Cash Management Plans

- Although all providers focus on paying their bills, consider relevant expenses for the first six months of ICD-10!
- If possible and needed, **renegotiate terms with major suppliers to create a more balanced payment schedule over time**
- Identify and implement other cost saving measures in advance of October 2015
  - Postpone major equipment purchases
  - Staff educational expenditures that can be delayed
- Aggressively manage devices / implants and other supply inventory levels to avoid expensive overstock costs
- Reduce other administrative overhead where possible

Cash Management Plans

- **Now is the time to reduce Accounts Receivable!**
- **Manage AR aging aggressively, minimize charge-offs and denied payments –**
- **Work all denials and rejections to eliminate their occurrence at the root cause and ensure more first time third party payer payments.**
- **If you have not already done so, adopt best practices, procedures, and products that will enable you to collect patient co-pays or deductibles at the time of patient encounter.**
- **Best practice – Consider improving internal strategies to ensure all charges are posted, claims are coded, pre-bill edits resolved, and claims submitted to all payors within a four-day bill hold.**

Payor Impacts

Communication!

- **Review contract negotiations or re-negotiations!**
- **Coverage determinations – Inpatient vs. Observation, OP**
- **Payment determinations through claim submission revisions**
  - **Any additional reporting changes in addition to ICD-10**
- **Medical review policies**
  - **If possible, investigate differences in specific diagnoses**
  - **Cardiology**
  - **Orthopedics**
- **Changes in "Plan" structures (per diem, DRG, capitated OP, fee schedule)**
- **Fraud and abuse monitoring – Compliance review**
- **Quality measurements and reporting software**

Project Management Plan

Know your Payors' Plans, Readiness Status, and TEST!

- **Review status of the dialogue or candid discussions with your primary third-party payers now! (Top 5 payors = 75% - 80% of cash?)**
- **Can you positively state where each one is with readiness?**
- **Ask (and document) all Payors if they are implementing new rules for claims submission or re-submission.**
  - **Medicaid in another state reducing appeal days from 120 to 90.**
- **Understand specific medical necessity revisions / requirements.**
- **Important to incorporate claims processing rules and medical necessity changes into staff ICD-10 education!**

Project Management Plan

Over-riding Question from CFOs –

How much cash flow should we put away in order to sustain our business? 6 months? 12 months? Longer?

- **There is no magic number that will work for every healthcare provider.**
- **Each situation is unique.**
- **Your specific situation will need to be carefully considered.**

Best guesstimate is 6 to 9 months reduction in cash receipts of 50%!

(Suggestions from HFMA ICD-10 Panel of CFOs at Region 11 in January 2015)

Documentation Needs

- The increased specificity of the ICD-10 codes requires more detailed clinical documentation in order to code some diagnoses to the highest level of specificity.
- There are "unspecified" codes in ICD-10-CM for those instances when medical record documentation is not available to support more specific codes.
- However, these may not be PAID!
- And, certainly will be paid as a lesser complexity or lower level service.
- The benefits of ICD-10 can not be realized if non-specific codes are used rather than taking advantage of the specificity ICD-10 offers.

Improving Documentation

- **Continue to conduct medical record documentation assessments**
  - **Evaluate records to determine adequacy of documentation to support the required level of detail in new coding systems**
- **Implement a documentation improvement program to address deficiencies identified during the review process**
  - **Educate providers about documentation requirements for the new coding system through specific examples**
  - **Emphasize the value of more concise data capture for optimal results and better data quality**
  - **Concurrent review of Inpatient documentation is best practice!**

Assessment of Educational Needs

Continue training!

- **Identify who will require education:**
  - **Coding professionals**
  - **Providers**
  - **Billing personnel**
  - **Clinical personnel**
  - **Administrative staff and Management**
  - **Researchers**

- **Determine what type and level of education each job role will need.**
  - **Assess the current level of coder education and experience.**
  - **Assess the level of knowledge necessary per person/role based on job responsibilities.**
  - **Determine the best method of education.**

Implementation Gap Analysis

- **ICD-10 CM and PCS Readiness!**
- **A Gap Analysis will need to be performed no later than September 1, 2015, to determine any potential areas that will be negatively affected; and**
- **A contingency plan will need to be developed, approved and implemented.**
- **Communication!**

Provider Impacts

Not "new" facts – but important for ICD-10!

- **We rely on providers to accurately document patient observations of medical condition (acuity of patient), care plans (intensity of services provided) and treatment findings (outcomes).**
- **Only through "descriptive" words recorded by the physician will coders be able to translate documentation into accurate coding.**
- **Accurate coding is necessary so that claims processing decisions can be made, which equals optimum payment!**
- **We should expect providers to have to spend about 15% more time on asking questions, observing, and documenting their findings to support the ICD-10-CM code set.**

Provider Impacts

- AHIMA reports that even with increased provider documentation, we can expect, with better coding, an increase in denials or pending claims, and the need for providers to submit additional documentation to support the codes.
- Consider lower productivity of coders, slower documentation and time needed for provider clarification, greater need for resolution of claim edits, problems with payor claims processing, and perhaps greater restriction of diagnoses that meet medical necessity – all of which translate into less cash that takes longer to collect!
- As noted, the time for preparation is now!

Five Necessary Operational Steps

Implementation and Operational Steps to Assess

- **Technology – system and program upgrades / installations**
  - **Vendor Readiness**
- **Payor Readiness (and claims processing knowledge)**
- **Operational processes / work flow analysis and written procedures**
- **Training – not just coders!**
  - **Physicians, other clinical staff members**
  - **Revenue Cycle staff members**
- **Evaluate current readiness status – and structure tasks for next 45 days (and beyond)!**

Five Necessary Operational Steps

Implementation and Operational Steps to Assess

- **Consider "Problem Resolution Team" available for staff member questions / issues – beginning one week before and continuing after Oct. 1 for as long as needed.**
- **Knowledgeable team members:**
  - **Information Systems**
  - **Patient Access leader**
  - **Patient Care Manager**
  - **Coder**
  - **PFS leader**
- **Identify a "ICD-10 Hotline" Number for questions / issues**
- **Record questions and send e-mail blast to all staff members**
- **Needed on evening shifts and week-ends particularly**

Basic Education Sites

- **NCHS – Basic ICD-10-CM Information**
  http://www.cdc.gov/nchs/about/otheract/icd9/abticd10.htm

- **CMS – ICD-10-PCS Information**
  http://www.cms.hhs.gov/ICD10/02_ICD-10-PCS.asp

- **AHIMA - ICD-10 Education**
  http://www.ahima.org/icd10/index.asp

- **AMA – ICD-10-CM Physician (specialty) Education**
- **http://ama-assn.org**

- **WEDI – ICD-10 Implementation**
  www.wedi.org

ICD-10 Assessment: The First Step

- **Questions? . . .**

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