ICD-10-CM: Less than 6 Months to Go Live!

McKesson Business Performance Services
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Bess Ann Bredemeyer
BSN, RN, CHC, CHPC, CPC
McKesson Business Performance Services

As the Senior Director of Consulting, Ms. Bredemeyer oversees the facility charge capture audit program and the physician coding and billing compliance consulting teams and she serves on McKesson’s ICD-10 planning and implementation steering committee. She works with hospitals and physician groups of all sizes and specialties on coding and compliance solutions.

Lisa Schroeder
CHC, CPC, CCS-P
McKesson Business Performance Services

As a Compliance Program Director, Ms. Schroeder has more than 20 years experience in practice management, AR management, medical coding and compliance. She serves on McKesson’s ICD-10 planning and implementation steering committee and has also been involved with developing and maintaining billing and compliance policies.
Bess Ann Bredemeyer and Lisa Schroeder are employed by McKesson’s Business Performance Services division which provides services to medical practices, hospitals and health systems on topics being addressed in this presentation.

Learning Objectives

• Identify the Challenges of ICD-10 Implementation
• Assess an Organization’s Readiness for Implementing ICD-10
• Define the Steps Necessary to Improve Clinical Documentation
• Share Lessons Learned from Early Adopters
Agenda

- Delay?
- ICD-9-CM vs. ICD-10-CM Overview
- Challenges
- Readiness
- Lessons Learned
- Q & A

Delay?
Most Providers indicated plans to “stay the course”

- **August 2012 Delay to October 1, 2014**
  HHS announces final rule for one year delay

- **March 2014 Delay to October 1, 2015**
  Section 212 of HR 4302, Protecting Access to Medicare Act of 2014
  “The Secretary of Health and Human Services may not, prior to October 1, 2015, adopt ICD-10 code sets as the standard for code sets....”
Survey

How far along are you in your preparation for the transition to ICD-10?

- 25%
- 50%
- 75%
- >75%
- Ready!

ICD-9-CM vs. ICD-10-CM Overview
ICD-9-CM and ICD-10-CM

Key differences

<table>
<thead>
<tr>
<th>ICD-9-CM Volume 1 &amp; 2</th>
<th>ICD-10-CM</th>
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</thead>
<tbody>
<tr>
<td>13,000 Diagnosis Codes</td>
<td>68,000 Diagnosis Codes</td>
</tr>
<tr>
<td>3- to 5-digit Codes</td>
<td>3- to 7-digit Codes</td>
</tr>
<tr>
<td>Code Format: Numeric Codes for all Chapters Alphanumeric for Supplementary Chapters (V-codes and E-codes)</td>
<td>Code Format: Digit 1 is alphabetic Digits 2-7 are numeric</td>
</tr>
<tr>
<td>No Dummy Placeholder</td>
<td>Presence of Dummy Placeholder</td>
</tr>
<tr>
<td>ICD-9-CM Volume 3</td>
<td>ICD-10-PCS</td>
</tr>
<tr>
<td>11,000 Procedure Codes</td>
<td>87,000 Procedure Codes</td>
</tr>
<tr>
<td>3- to 4-Digit Codes</td>
<td>7-Digit Codes</td>
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</tbody>
</table>

Benefits of Specificity

- ICD-10-CM incorporates much greater clinical detail and specificity than ICD-9-CM.
- Terminology and disease classification are updated to be consistent with current clinical practice.
- The modern classification system will provide much better data for multiple purposes.
Challenges

ICD-10 will change everything. Will you be ready?

Physicians
- Documentation: The need for specificity dramatically increases by requiring ICD-10 codes, and may require a retraining of staff.
- Code Changes: Codes increase from 15000 to 140000.
- Training: Physicians must be trained.

Clinical Area
- Patient Coverage: Health plan policies, payment limitations, and new ABN forms are likely.
- Registries: Registries required for non-new patients may be impossible.
- ABNs: Health plans will require all policies linked to ICDs or NCDs, etc. ABN forms must be reformatted and sent electronically.

Managers
- New Policies and Procedures: Any policy or procedure associated with diagnosis codes, disease states, or treatment, or billing, or QIO must be reviewed.
- Vendor and Payor Contracts: All contracts must be evaluated and updated.

Nurses
- Forms: Every order must be reviewed or restructured.
- Documentation: Must use increased specificity.
- Training: Policies may change, requiring training and updates.

Lab
- Documentation: Must use increased specificity.
- Reporting: Health plans will issue new requirements for the ordering and reporting of lab work.

Clinicians
- Policies and Procedures: All payor reimbursement policies may be revised.
- Training: Billing department must be trained on new policies and procedures and the ICD-10 CM code set.
- Code Changes: Codes increase from 15000 to 140000. As a result, code lookups will completely change.
- Training: More detailed knowledge of anatomy and medical terminology will be required with increased specificity and new codes for drug therapy.
- Concern: The clinician may need both ICD-9-CM and ICD-10 CM concurrently for a period of time until all changes are realized.
ICD-10 will change everything. Will you be ready?

OFFICE MANAGERS
- New Policies and Procedures
- Updated Vendor & Payer Contracts
- Budget for Software Upgrades

CODERS and BILLERS
- Learning curve of new ICD-10 codes
- Payer reimbursement policy changes
- Use both code sets (ICD-9 & ICD-10) for a period of time
ICD-10 will change everything.
Will you be ready?

NURSING and CLINICAL STAFF

- More Specific Documentation
- Authorization policy changes
- Form changes

PHYSICIANS and PROVIDERS

- More Specific Documentation
- 5x Code Set Increase
# Are You Prepared For This?

## Today

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<thead>
<tr>
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<tbody>
<tr>
<td>Claim file to payer</td>
<td>Payer processes claim file</td>
<td>Remit rec’d; pmts &amp; adjs posted</td>
<td>Follow-up done on $1,000.00</td>
<td></td>
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<tr>
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<td></td>
<td>$3,000.00</td>
<td>$1,280.00</td>
<td>$320.00</td>
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</table>

## Post ICD-10 Implementation

<table>
<thead>
<tr>
<th>Day</th>
<th>Day 15-20</th>
<th>Day 20-25</th>
<th>Day 26-30</th>
<th>Day 30-35</th>
<th>Day 36 -</th>
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</thead>
<tbody>
<tr>
<td>Claim file to payer</td>
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<td></td>
</tr>
<tr>
<td>$5,000.00</td>
<td></td>
<td></td>
<td>$2,500.00</td>
<td>$800.00</td>
<td>Pat – $200.00</td>
</tr>
</tbody>
</table>

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## Survey

Are your coders fully trained and prepared to code in ICD-10?

- Yes
- No
- Don’t know
Readiness

January – April 2015 Timeline
Did you?

1. Evaluate current cash flow (age of account balances, billing lag time)
2. Set goals and plan to correct/prevent recurring errors/issues and optimize cash flow
3. Determine impact on quality initiatives (e.g., PQRS, EHR)
4. Complete ICD-10 training at all levels
5. Follow-up with electronic system vendors
6. Note payer news regarding ICD-10 claims testing requirements/opportunities
7. Review insurance contracts for diagnosis-based payment impact
8. Revise/develop/purchase internal coding resources (encounter forms, coding quick references)
January – April Timeframe

1. Focus on frequently used codes
   - Top 100
   - Unusual codes, unusual volume
   - Training

2. Reduce average days to final billing
   - Days not billed
   - Benchmark
   - Prepare

Other Questions to Consider

• Are upgrades completed or scheduled?

• Should 2014 reporting be completed prior to system upgrades?

• Is training on upgraded system necessary and if so, scheduled?
### September 2015 Timeline
**Action items**

1. Develop and assign workflow and processes effective 10/01/15
2. Verify that all testing was successfully completed
3. Consider direct-to-payer or other alternative claims submission resources (if testing has not been successful)
4. Continue to monitor payer news regarding readiness and changes to payment policies

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### October 2015 – Ongoing Timeline
**Action items**

1. Monitor all claims acknowledgement (997) and acceptance/rejection (277) reports
2. Promptly correct and resubmit all rejected/denied claims
3. Evaluate post-implementation cash flow until claims filed with ICD-10 are consistently paid
4. Evaluate need for contingency activities (e.g., overtime, consultant, credit line)
5. Conduct coding review for accuracy and compliance
6. Monitor reimbursement accuracy and timeliness of payer per contract
7. Continue to monitor payer news regarding claims adjudication issues and resolutions
Survey

Which do you think will impact your staff productivity the most?

- Increase in volume of codes
- Requirement to dual code in both ICD-9 and ICD-10
- Inadequate documentation of medical records
- Staff unclear of roles during implementation
- Lack of certified Staff
- New technology systems

Lessons Learned
Clinical Documentation
Key to a successful ICD-10 transition

Implement clinical documentation improvements found during compliance audits
- More detailed medical records
- More time to translate/interpret
- Increased delays in authorizations
- Increased claim rejections
- More time to research/resolve reimbursement issues
- Increase queries for documentation by facilities
- Same notes used in facility and office

This breaks down to two major motivations for CDI:

1. **Patient care**: Complete and accurate medical records are needed to help ensure the patient gets the right treatment.

2. **Cash flow**: Medical claims are rejected and down-coded because there is not enough documentation to support a diagnosis.
Clinical Documentation
Key to a successful ICD-10 transition

Key Steps to Improving Clinical Documentation

1. Assess documentation for ICD-10 readiness
2. Analyze the impact on claims
3. Implement early clinician education
4. Establish a concurrent documentation review program
5. Streamline clinical documentation workflow

Training

- Education is a critical factor in a successful implementation of ICD-10 requiring a comprehensive training program
- Education should include coders as well as providers
- Implement the training in phases
  - Anatomy and pathophysiology refresher training
  - ICD-10 General Guidelines
  - Code Set Training
- Was the training successful – measure the outcomes
  - Did the training accomplish the objective?
  - Have the coders/providers developed a level of proficiency?
  - Consider dual coding for a period of time to measure proficiency
Productivity

• Learning curve with compromised short-term productivity
• With continued due diligence, the coders and providers will become comfortable with ICD-10 and gradually productivity will increase.
• Do you know what your productivity is today?
  – American Academy of Professional Coders: coding productivity can be reduced by as much as 30-40% until the learning curve has been realized
• Factors influencing decrease in production:
  – Specialty
  – Coder knowledge
  – Provider documentation

Accuracy

• Another area of concern is the increase of auditing charges for compliance in order to comply with the more extensive documentation that ICD-10 requires.
  – Dual Coding – consider having the coders code in both ICD-10 (translation to ICD-9 through the GEMS crosswalk)
  – Audit the ICD-10 code to help ensure accuracy
  – Does the documentation contain the specificity to code in ICD-10?
  – Is additional provider training warranted?

• In our testing environment, the accuracy rate of coders quarterly QA scores decreased by a minimal amount
  – Factors influencing decrease in accuracy
    • Specialty
    • Coder comprehension of training
ICD-10: How to decrease the billing impact

- **Identify** your current systems which will need to migrate to ICD-10, such as clinical documentation, electronic health records, contracts and vendors, and reporting protocols.
- **Contact** your payers as ICD-10 may mean a modification of contracts, payment schedules, or reimbursement.
- **Assess** your facility to determine how the transition may disrupt or slow the billing process.
- **ICD-10 implementation and readiness testing** should be discussed with everyone in your billing chain to help ensure a smooth transition.
- **Test and report** documentation and billing for accuracy.

ICD-10: How to decrease the central business office impact

- Review all super bill’s and charge tickets for ICD-10 accuracy
- Review compliance strategies in the CBO
- Review any AR charge editing software
- Determine the coder’s responsibilities in the CBO
- Training for staff that will process charges
Top Reasons for Expected Decrease in Revenue

What will impact your revenue the most?

- 47% Incomplete physician documentation
- 11% Coding staff mistakes
- 15% Payers not ready
- 12% Shift in DRGs

Source: Health Leaders Survey
http://content.hcpro.com/pdf/content/268585.pdf

ICD-10: How to decrease the central business office impact

Claims Validation and Processing
- New edits based on new payer proprietary rules.
- On-going builds of new edits increasing as payers refine adjudication criteria
- Changes as coding conventions for modifiers, injury codes, V codes, etc. may be replaced with more granular ICD-10-CM coding

Claims edits must be flexible and able to be customized
Survey

As a healthcare leader, where is your main focus over the next 8 months as you prepare for the transition to ICD-10 on Oct. 1?

- Hiring certified coders
- Training existing coders
- Selecting outsourcing vendor for coding services
- Testing in ICD-10
- Educating Physicians
- Clinical documentation audits
- Compliance planning
- Technology upgrades
- Payer readiness
- Revenue implications
- Staff productivity implications

Points to Remember

- Preparation and planning is key to the success of the implementation
- Sufficient education is a must
- Understand the limitations of working with the systems (ICD-9 and ICD-10) in tandem
- Learn from the experience of others
Resources

- American Hospital Association (AHA)  
  www.ahacentraloffice.org
- American Medical Association (AMA)  
  www.ama-assn.org/ama
- Center for Disease Control CDC)  
  www.cdc.gov
- Center for Medicare & Medicaid (CMS)  
  www.cms.gov
- American Health Information Association (AHIMA)  
  www.ahima.org
- American Association of Professional Coders (AAPC)  
  www.aapc.com
- Medicare Benefit Policy Manual, Ch 15, Sec. 80.6  

Q&A