Preparing For ICD-10 CM: Effects & Expectations

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Your Presenter Today

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Which Are You?

• Overwhelmed?

• Peeved?

*Future State: Shrugging or Tranquilizers*

*Future State: Angry or Outta Here*
What Kind of ICD-10 Journey?

• Wait till the mountain is upon you, grab your determination and ...

• With Care & Planning.....
Today’s Program

A. This Session:
   1. What is Coming & Why
   2. Impacts & Likely Adjustments
   3. Essential Need For Planning & Being Organized

B. Break-Out Session:
   1. Technology & Practice Impact Assessment
Section #1

What’s Coming?
Why?
Expected Benefits?
What’s Coming and Why?
What Billing Codes Are Changing?

- Diagnosis codes - ICD-9 → ICD-10
- Procedure Codes – CPT Codes
- Product Codes – HCPCS (part 3 of ICD-9)
History

• Authored by the World Health Organization
• ICD-10 is not a new idea
  – First proposed in 2005
• Originally US target date was 10/1/11
• Moved to 10/1/2013 to allow EHRs to get underway first
• Moved the target to 10/1/2014 in response to AMA (and others’) request
Target Will Move Again?

• Date will not move again
  – Too much hinges on ICD-10
    • Outcomes-based reimbursement incentives
      – Accountable Care Organizations
    • Payer process improvements
  – Many millions already invested

• US will not jump to ICD-11?
  – Too much already invested into ICD-10 readiness
Drivers

• ICD-9 structure prohibits logical code growth to respond to the evolution of medical science
• More consistently align with the rest of the world (SNOMED)
Improvements in ICD-10

• Code structure that is logically constructed
• Provide greater anatomical specificity
• Provides for more specific description of patient condition
• Provides for indication of sequence or etiology
• Provides anatomical details to support greater research, especially with injuries
• Greater differentiation for newer therapies to permit better value and efficacy research
Value From Ability to Differentiate the Newer Treatments & Technologies

• Newer treatments can have pricing that recognizes their differences
• Outcomes and efficacy research can better isolate the differing treatments and technologies
Scenario of the New Code in Use

Our patient visits the doctor’s office and is diagnosed with a closed greenstick fracture of the right radial shaft.
Logic of the ICD-10 Code

| S52.311A | Greenstick fracture of shaft of radius, right arm, initial encounter for closed fracture |

<table>
<thead>
<tr>
<th>Root 1</th>
<th>Root 2</th>
<th>Root 3</th>
<th>Site</th>
<th>Severity</th>
<th>Etiology</th>
<th>Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>A</td>
</tr>
</tbody>
</table>

- Injury, poisoning and certain other consequences of external causes
- Injuries to the elbow and forearm
- Fracture of the Forearm
- Radial Shaft
- Greenstick
- Right
- Initial Encounter

1 | 2 | 3 | 4 | 5 | 6 | 7
Type of Characters in the Codes

- First character is always alpha
- All the letters except U are used.
- Character 2 is numeric.
- Characters 3-7 can be alpha or numeric.
- Just as in ICD 9, there is a decimal after 1st 3 characters.
Structural Comparison

Remember:
Our patient visited the doctor’s office and was diagnosed with a closed greenstick fracture of the right radial shaft

ICD-9
813.21
Fracture of radius and ulna; shaft, closed radius (alone)

ICD-10 CM
S52.311A
Greenstick fracture of shaft of radius, right arm, initial encounter for closed fracture
Greater Details = More Codes

ICD-9
ca 14,000 codes

ICD-10 CM
ca 68,000 codes
Sneak Peek:
Some Areas That Will Be Impacted

– Diabetes Mellitus
  • From 59 codes to over 200 codes

– Injuries
  • A 7th character extension identifies the encounter type
  • “A” for initial and “D” for subsequent
  • Also code the size and depth (this MUST also be documented in the notes)
Sneak Peek:
Some areas that will be impacted

• Musculoskeletal conditions
  – ICD 9 currently has 8 codes for pathologic fractures
  – ICD 10 will have more than 150 codes to describe this same area.
ICD-10 Manual Structure

• No big changes
  – Alpha Index
  – Tabular Listing
Content of the Alpha Index

• Look up starts here
  – Index of Diseases & Injuries
  – Index of External Causes of Injury
  – Table of Neoplasms
  – Table of Drugs and Chemicals
Structure & Purpose of Tabular Listing

- Codes are **only** located in their respective bodily system area
  - Lookup is more logical than at present
  - Should be faster after people get comfortable

- Searching for the code:
  - Start with the Alphabetical Listing
  - Be sure to consult the Tabular List to determine if additional coding may be required
Expected Benefits - 1

Supporting Quality Improvement at the Community Level
• ICD-9 is obsolete and no longer reflects current clinical knowledge, contemporary medical terminology, or the modern practice of medicine, and its
  – limited structural design lacks the flexibility to accommodate advances in medicine and medical technology.
Data Comparability

• On the international front
  – Continued use of ICD-9 only hinders US efforts to gather clinically relevant and internationally comparable data.

• On the national front
  – The US has been using ICD-10 for mortality reporting since 1999, so continued use of ICD-9 prolongs the time in which US mortality and morbidity data are not comparable.
Value of Inclusion of Sequence or Etiology

• Greater understanding of the prevalence of certain conditions that lead to various diseases or illnesses

• Future ability to respond to emergent conditions
Identification of Needed Prevention Programs & Policies

• Allowing for identifying potential conditions that may be more prevalent in the specific company/contract/population
  – i.e.; Comparing prevalences of certain conditions (e.g., diabetes, hypertension, high cholesterol, or heart disease) among health plan enrollees with estimates from national databases (e.g., NHANES, NHIS, or BRFSS)
Further, analyzing the conditions in terms of job type, socioeconomic status (SES), and other demographic categories may help in targeting interventions and developing policies.

Look at socioeconomic status and the percent of out-of-pocket costs for prescriptions.
Reduction in Fraud Rate

• Reductions in fraud is expected from the shift to these more specific new codes
  – Much fewer opportunities to use non-specific codes
Expected Benefits - 2

Supporting Quality Improvement at the Practice/Clinic Level
More Appropriate Payments for Procedures

• More adequate coverage and reimbursement for new procedures (no codes at present)
  – New procedures can be separately processed
  – New procedures can be uniquely reimbursed
  – Should mean that Medicare and other payers can actually include coverage for high-cost but high impact procedures
Fewer Miscoded, Rejected and Improper Reimbursement of Claims

- Codes will be less ambiguous and become more logically organized and detailed.
- Initially there may be more errors and it may take a few years to fully grasp proper coding for the best reimbursement.
Value of Inclusion of Patient Condition in Code

• Relates to an existing standard factor from a patient clinical evaluation
• Provide information on patient condition complexity
  – This data is expected to reduce the necessity of supplemental documentation
  – Will allow payers to more easily set differential rates
    • Especially with value-based payment systems
  – Will allow care quality reporting systems to factor patient condition in provider incentive systems as P4P
Segment #2

Impacts and Likely Adjustments Needed for Adaptation
Internal Operations
High Level View of Impacted Areas

1. Clinical documentation
2. Encounter forms and superbills
3. Follow-on services (referrals, etc)
4. Existing contracts
5. Practice management system (PMS)
6. Electronic Medical record system/EHR
7. Patient/disease registries
8. Quality reporting processes/formats
9. Public health reporting (immunizations and communicable diseases)
1. Clinical Documentation
6. Electronic Medical record system/EHR

• Your chart must include the following information to support the selected ICD-10 code;
  – In some cases, it depends on the nature of the selected code, but as a general rule the following must be documented:
    1. Underlying patient condition(s); all relevant conditions
    2. Symptoms & signs when no confirmed diagnosis
    3. Indication of any history, sequelae, or stage of condition
    4. Indication of an impending or threatened condition
    5. Designation of side for any potential bilateral conditions
    6. Specify the service(s) provided during the encounter
2. Encounter Forms & Superbills

- Remember, these are *not* considered clinical records
- Pre-printed forms that are used to document the charges (services provided), via procedure codes, for a patient visit. Can also include supporting information, such as diagnosis codes, that will be required to actually bill insurance companies.
Considerations for the Encounter Form/Superbill

• How many conditions do you want to include on the form?

• Do you want to have the processing staff examine the chart to determine the proper ICD-10 Code?
  – Your biller is now coding

• Do you want practitioner to designate proper ICD-10 Code?
  – Means greater info displayed on the form
3. Follow-on Services (Referrals, etc)

- Your ancillary service providers will be looking for the new ICD-10 Codes
  - They will be expected to justify their service claim to the payer, too. Your diagnosis code is key for them.
  - Same with your consult request
- If you send an electronic request via your EHR, the data set will eventually require it
  - Hopefully your EHR solution assists in actual ICD Code selection
    - Should your practitioner make this final selection?
4. Existing Contracts

- ICD-10 Codes provide a greater degree of payment differences to reflect complexity
  - You should find payers seeking to make use of this ability to have individual fees for each code to reflect the inherent complexity of the work/service
5. Practice Management System (PMS)
6. Electronic Medical Record System (EMR)

- These 2 systems must be able to handle the larger size of the ICD-10 Codes.
  - You should expect and plan for a software upgrade
- You will need to update every diagnosis code for your active patients
  - Hopefully your vendor is building a ICD9 code converter that you can use
    - You must plan for a certain amount of manual conversions
      - There are MANY instances where there is not a 1:1 change or a clean equivalency
7. Patient/Disease Registries

- Outsourced (ASP) registries will be changing to the ICD-10 Codes

- If you use a separate system at your office, you should expect an upgraded product from your vendor
  - You will need a coordinated upgrade plan with your EMR
8. Quality Reporting Processes/Formats

• Payer quality reporting programs will be changing to ICD-10 Codes
  – The additional dimensions provided by ICD-10 Codes are especially relevant to quality incentives because the include descriptions of severity and sequelae
9. Public Health Reporting
(Immunizations, Communicable Diseases, Vital Records)

• This reporting will convert to ICD-10 Codes
• Will achieve consistency with US Morbidity reporting
  – Is now on ICD-10
External Partners & Relationships
1. Payers

• Contracts
• Claims submission
• Prior authorization
• HEDIS reporting
• P4P incentives
• PCMH incentives
• EHR adoption incentives (not with Stage 1)
• Auditing
2. Billing Services & Clearinghouses

• Billing services
  – Sufficiency of the encounter form

• Clearinghouses
  – Not clear if any will offer ongoing ICD-9 Code-ICD-10 Code claim translations
    • If they do, there will remain need for manual coding and related customer charges
3. Ancillary Providers

• They will need ICD-10 Codes on all orders to secure payments from the payers for their services
4. Inpatient Settings

- Hospitals will converted to ICD-10 CDM codes at the same time as practitioners convert to ICD-10 CM codes
  - MGMA is arguing that changes should be in 2 stages
    - Hospitals first
    - Then the practitioners
- Hospital ICD-10 codes are actually *procedures*, not diagnoses
5. Consulting Physicians

• They will most likely be using ICD-10 Codes to be paid for servicing your patient
• They will need your presumptive diagnosis ICD-10 Code
6. Researchers & Peers

• The ICD-10 Codes will be the national common language of diagnosis
  – Any organization you work with performing medical investigation and/or publication will be doing so based on ICD-10 Codes
Segment #3

Essential Need For Planning
And Being Very Organized
Segment #3 Topics

1. Planning
2. Risk Management
3. Change Management
4. Communications
5. Cut-Over Readiness
Planning: The Secret Sauce
Starting Out: Scope

• Set Project Scope:
  – Determine how ICD-10 is going to impact you
    • Explore the factors that have been described today
      – What practice tasks must change, and how?
      – What will you have to create?
    – Decide what approach you will use to work on those factors
      • Who?
      • What tools/techniques?
So What Are the Major Things That Must Happen?

• People must learn the new coding system
• The computer systems that use the new codes must change
• Providers must adopt more detailed clinical documentation
• Key forms will have to be changed
• People must be trained
Starting Out: Work Breakdown a/k/a Whittling It Down To Size

• Given your scope, what is all the work that has to be done?
  – Literally, look at all the changes (individually), and think a bit about the work that must be done for each of them to create that change and make it operational
  – Think about who is the right person to do this work
    • Could be an outsider
    • Could be an promising staffer that must get some training
Tools: Diagramming Helps

- Implement ICD-10
  - Impact analysis on relevant 10Codes
  - Upgrade systems
  - Restructure encounter document and flow
  - Training staff
  - Conversion of diagnosis codes for active patients

- Attend AHIMA Seminar
- Identify special provisions for care groups
Starting Out: Getting The Dependencies Right

• Look at the work you have identified
  – What logically must come before what?
    • You cannot start testing with your payers until you have upgraded or converted your PMS
Starting Out: How Much Effort?

• The last important input to producing your plan is estimating the effort required to get each piece of work done.
  – Doing it at this level will help to make it realistic
    • Key to staff scheduling
    • Key to being ready to do the work without delay

**QUESTION: Delays = ????**
You Are Ready To Build Your Project Schedule
[You Have Already Been Planning]

• After all:
  – You now know the work you have to do
  – You now know the dependencies of the work
  – You now know how long each piece of the work will likely take
You Must Work Around Some Key External Dates

- Of course, there is the federal cut-over target
- Each payer has windows for testing claims
- Valuable town-halls, information sessions, webinars and the like will be set for certain dates

Put another way, you must be mindful of the dates & communications by outside entities....
Why A Detailed Plan Is Not Optional

• You face a hard stop – 10/1/14
• You are late getting started
• Changes are always unsettling
  • Plans reduces the scale of the unknown
  • Deliverables build confidence
• Target dates allows assigned staff to be ready for their assignments
• Delayed work nearly always means increased costs
• Target dates for activities help you judge how well you are coming along
  and are a good indicator of how you will end up
• There are significant number of parallel tasks that must come together at
  the right time
  – If they fail to come together appropriately, delays and increased costs are highly likely
Controlling Things You Do Not Control [i.e.; payers]

- Talk with external entities and become familiar with how they are approaching their ICD-10 change-over
  - Ask lots of questions
  - Be very respectful
    - Remember, they are coping with change just like you are
    - Remember, your contacts are NOT driving the bus
    - Share your predicament and ask for help/suggestions
  - Find a Radar O’Rielly and nurture him or her
Plans are Not Just Schedules: Strategies & Approaches are Also Plans

- Changed processes that will be used (who has what role)
- Approaches for staff orientation and engagement
- Settle on opportunities for process re-engineering and make decisions
- Current patient 9Code conversion methods
- Methods and focus that will be used for testing/validation of system readiness for go-live
- Communication methods that will be used with patients and external partners on coming changes
- Training planning and approaches for on-site staff support at go-live
Extent of Coordination You Will Need

- **Medical staff** will need to define/confirm clinical process changes
  - Templates for flow sheets, documentation, encounter forms, etc.
- **HIT solution Vendor** will need to deliver guidance to your upgrade or conversion efforts for your PMS, or EMR (especially if you choose to implement one)
- **Office staff** will need to define clinical information flow, claims processing, and patient flow changes that may be needed
- **Technology services** personnel must deliver any additional hardware to be located locally *before* it is needed
- **Payers** need to arrange for you to conduct a validation that your ICD-10 Code-based claims are going to process successfully after 9/30/14
- **Billing outsourcer** if currently used
Sustaining Focus & Support

• Your plan shows that it will take a sustained effort over a longer time than folks had originally presumed.
• Implementing essential process changes early forces practice-wide attention periodically.
• Accomplishing results along the way reminds everyone and breeds confidence.
• Including the topic of ICD-10 as part of standing agendas for staff meetings.
• Consider a progress thermometer that everyone can see changing over time.
Risk Management
Key Concepts in Risk Management

• Spend time thinking about what might go wrong
  – Areas of significant unknowns or matters largely out of your control

• Perform qualitative risk analysis
  – Determine which risks, should they materialize, could hurt your patients or your business

• Perform a quantitative risk analysis
  – Estimate the likelihood of the risk materializing

• Monitor potential risks and control them

• Implement risk mitigation plans for hi-impact areas
What Risks Can Apply to Most Practices?

- Immediate revenue and cash balance challenges (up to 90 days) due to:
  - Claims with 9Codes after 10/1/14 will be rejected by all governmental payers
  - Many payers plan to reject unspecified codes for further documentation
    - If you must, provide explanation
  - Misfiled claim (wrong ICD-10 Codes) rates will be high initially (90 days or so) and error processing will get bogged down
Mitigation Plans

• Develop risk off-setting arrangements for high probability or high impact risks:
  – Early implementation of complex documentation changes before ICD-10 goes into effect
  – Code change validation provisions for each of your systems
  – Take advantage of every payer’s program to allow you to test your ICD-10 Code submission processes
    • Electronic or paper submissions
    • Perform these tests earlier than later to avoid the last minute deluges
Clinical Documentation Risk Points

• Elements of encounter documentation needed by ICD-10 are missing
  1. Underlying patient condition(s); all relevant conditions
  2. Symptoms & signs when no confirmed diagnosis
  3. Indication of any history, sequelae, or stage of condition
  4. Indication of an impending or threatened condition
  5. Designation of side for any potential bilateral conditions
  6. Specify the service(s) provided during the encounter

*These are the factors we discussed earlier on slide 28*
Consequence of Clinical Documentation Risks

- If manually coded, the coding effort will be delayed resulting in longer average payables duration – delayed revenue
  - For many diagnoses, there is no “other” code, so your biller/coder must find the missing data to be able to choose among the code options, including questioning the practitioner in some cases

- If an ICD-10 Code is used for which there is insufficient documentation, a subsequent audit will likely result in a refund request or worse
Manual Clinical Documentation
Risk Mitigation Strategies

• Adjust documentation formats to explicitly capture new factors
• Make sure practitioners understand how the ICD-10 Codes have changed what is needed
• Implement changes early so that practitioners have enough time to adjust to the new expectations long before 10/1/14
Electronic Clinical Documentation
Risk Mitigation Strategies

• Examine the data that is captured by your EMR to validate that it will indeed capture ICD-10 Code-needed factors
  – Get guidance from your vendor, but do your own validations
  – Many current EMR products will NOT be able to meet this standard; You should expect to have to purchase and pursue an upgrade – validate the situation with your vendor
    • We described earlier the possibility of a conversion to another EMR vendor

• Presuming your EMR has provided 9Code assistance or recommendations, will it be able to assist with ICD-10 Codes?
Manual Billing & Claims Mitigation Strategies

• Devise encounter form(s) that
  – help convey needed information to determine ICD-10 Code
  – Provide visual code determination
  – Beef up the physiology knowledge base of your back office staff
Electronic Billing & Claims Risk Mitigation Strategies

• Begin now to determine if your PMS must be upgraded or replaced
  – An upgrade will take months, and a conversion will take many months
  – Remember that it must handle ANSI 5010 and ICD-10 Codes
Role of Validation in Risk Mitigation

• Never presume that a change will work just because the change is in place
  – You should always validate that the change actually works – that it produces the intended output
  • Give it
    – An adequate test (sufficient number of examples)
    – Test all the potential permutations

• Always presume that your design could be flawed
Examples of Validations

• Do not directly enter revised data
  – Set up data conversion tables to use to enter data
    • This will allow another staffer to quickly sample and QC the data entry effort
    • If you can use a PMS data batch loader, you can simply use the table
  
• Never totally trust an automated data loader or converter
  – Always perform a post-conversion validation
Examples of Validations (con’t)

• Always pilot run (use in live office operations) a new process to make sure it works and does not produce unintended negative consequences
• Insist in pilot runs with such business partners as outsourced billers
• All electronic transactions with payers should go through your payer’s ICD-10 Code testing process
Change Management
Essential Ingredient - Training

• Training is a critical step ensuring that staff is
  – knowledgeable about the ICD-10 code set
  – prepared for using the new codes appropriately.

• Different staff within your practice will require different training based on their involvement with the diagnosis codes.

• Training should focus on
  – learning the ICD-10 code set, and separately,
  – any work flow changes
Need For Mutual Commitment

• There must be genuine visible support from administration.
• The team must have a committed leader
• Team members must all play some vital part of the project/work
• The team must be united in the purpose and goals
• The team must have a focus
• Team members need to be in the right position
Essential Ingredient - Leadership

• A leader takes followers from where they are located to where they should be.
• All leaders confront change.
• Followers must be prepared for change.
• The leader must know what to change.
• Must pursue 360° communications constantly.
Tolerance for Learning

- A team is only as strong as it is disciplined.
- Effective teams realize that failure may be a step toward success.
- People need to be allowed to make mistakes.
- Teams must achieve a significant comfort level within the organization scheme.
- Communication is crucial.
Communications
Key Principles

• The larger the number of individuals involved, the increased importance of formal communications
  – Remember: The work of everyone in the practice is impacted

• External service entities, especially those that do not service you exclusively, require formalized communications
  – Remember: Physician practices never work in isolation
So Who is the “Enterprise”?

• You
  – Practice staff
• Business partners
  – Payer staff
  – Hospital staff
  – Ancillary service provider staff
  – Home care provider staff
Duration of Communications

• Not a one-time event – throughout project
  – At the outset everyone (internally) needs to understand the vision/goals/drivers
  – Sharing progress is vital to
    • Sustaining support
    • Assuring that future resources will be ready on schedule
  – Inform external entities at relevant moments
    • Help them stay focused on your needs and dates
Cut-Over Management
The “science” here is the following principles:

- Think about it [your future-state] **thoroughly**
  - Thoroughly includes involving the impacted people, not just management or the experts

- **Think about it ahead** so you can prepare provisions for what might go wrong

- **Train everyone** on the new way of doing things
  - No one is granted a pass from training (yes, not even the practitioners)

- **Generate excitement** over the coming achievement and resulting gains to the practice

- Provide immediate, at-the-elbow **support**, if required
Monitoring the Process

• Mistakes will happen.
• There will be greater mistakes at the beginning of the process.
• It is better to catch the mistakes early in the process than to deal with the issues as they compound.
Opportunities for Monitoring

• Encounter Form
• Capturing the Encounter count
• Creating the tickler file
• Maintaining compliance throughout the process
• Proper documentation
• Auditing the medical record
• Accounts Receivable follow up
  – Adjustments
• Communicate, communicate, communicate
Good Information Sources


http://www.himss.org/ASP/topics_icd10playbook.asp
Ready to Get Started?
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