Resiliency Strategies for ICD – 10

Rob Borchert, President
Best Practice Associates, LLC

Lorrie Borchert, President
Best Practice Training Institute, LLC
Agenda

- Mappings
  - GEMS
  - Specific Examples

- Impacts
  - Hospital/ Physicians/ Payors
  - Revenue Cycle Specifics

- Payor Perspective

- Strategies
  - Internal Projects
  - Outsource Considerations

- Resources
ICD Code Difference

CM - Clinical Modification

<table>
<thead>
<tr>
<th>Series1</th>
<th>ICD9</th>
<th>ICD10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13000</td>
<td>68000</td>
</tr>
</tbody>
</table>

PCS- Procedure Coding System

<table>
<thead>
<tr>
<th>Series1</th>
<th>ICD-9</th>
<th>ICD10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11000</td>
<td>87000</td>
</tr>
</tbody>
</table>
Mapping Between Old And New Systems

• General equivalence maps (GEMs) between ICD-9-CM and ICD-10-CM/PCS have been developed

• GEMs do **NOT** equal crosswalks

• Reimbursement map added to CMS web site in 2009
  – Intended for use by payors
  – Temporary mechanism
  – Allows claims processing by legacy systems
  – Allows for data collection for reimbursement changes

• Maps should **NOT** be used for coding medical records
Mappings

Cannot determine a correct crosswalk without additional clinical information.
Medical Policies could apply to both codes or only one.

A single ICD-10 code does not convey the clinical intent or reimbursement mapping of the ICD code.
GEMs Mapping

ICD-10 CM GEMs Mappings (Diagnosis)
- 1-to-1 Approx Match 82.7%
- 1-to-1 Exact Match 5%
- No Mapping 1.2%
- Complex Mappings 0.2%
- 1-to-1 Approx Match w/Multiple Choices 4.3%
- 1-to-Many (Single Scenario) 6.6%

ICD-10 PCS GEMs Mappings (Procedure)
- 1-to-1 Approx Match 92.4%
- 1-to-1 Exact Match 0.1%
- No Mapping 0%
- Complex Mappings 0.4%
- 1-to-Many (Single Scenario) 2.3%

© 2010 Deloitte Development LLC. All rights reserved.
CMS GEMS vs. CMS Reimbursement Mappings

CMS Reimbursement Mappings, which can be thought of as a crosswalk, eliminate alternative paths for ICD-10 to ICD-9 mappings to enable such scenarios as accepting ICD-10 claims but adjudicating internally against ICD-9.

In situations where there are alternative mappings, the CMS Reimbursement Mappings provide the most common conversion based on real world data; plans may need to validate these mappings.

Source: Deloitte Consulting presentation “Do Not Underestimate ICD-10’s Impact on Population Health Management” at the Forum 10 in Washington, DC 10/15/10
When should GEMS be used?

• To convert databases such as:
  – Payment systems
  – Payment and coverage edits and policies
  – Risk adjustment logic
  – Quality measures
  – Disease management programs
  – Utilization/case management systems
  – Financial modeling
  – Variety of research applications involving trend data

• To translate coded data for comparing data across transition period
When should GEMs NOT be used?

• When you have access to the medical record?
• When you have access to text descriptions or clinical terms describing the diagnosis or procedure
• When a small number of codes are being converted
• GEMs should NOT be used for coding medical records!!!!
Examples of Quality Problems With Current ICD-9-CM System

Example – Fracture of wrist:
- Patient fractures left wrist
  A month later, fractures right wrist
- ICD–9–CM does not identify left versus right

ICD–10–CM describes:
- Left versus right
- Initial encounter, subsequent encounter
- Routine healing, delayed healing or nonunion
Diagnoses Will Look Different

- ICD–9–CM currently has 3–5 digits
  - Example ICD–9–CM: 810.00
  - (fracture of clavicle, closed, unspecified part)

- ICD–10–CM has 3 – 7 characters
  - Example ICD–10–CM: S42.001A
  - (fracture of unspecified part of right clavicle, initial encounter for closed fracture)
Sports Medicine

Hit by a ball - ICD-9-CM code: E917.0

ICD-10-CM possible code

• W21.00 – Struck by hit or thrown ball, unspecified type
• W21.01 – Struck by football
• W21.02 – Struck by soccer ball
• W21.03 – Struck by baseball
• W21.04 – Struck by golf ball
• W21.05 – Struck by basketball
• W21.06 – Struck by volleyball
• W21.07 – Struck by softball
• W21.09 – Struck by other hit or thrown ball
ICD-10-PCS Code Structure

ICD-10 PCS Code Structure:

<table>
<thead>
<tr>
<th>Section</th>
<th>Root Operation</th>
<th>Approach</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Body System</td>
<td>Body Part</td>
<td>Device</td>
<td></td>
</tr>
</tbody>
</table>
ICD-10-PCS Example

Interphalangeal fusion of right great toe, percutaneous pin fixation

OSGP34Z

<table>
<thead>
<tr>
<th>Section</th>
<th>Med/Surgical</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body System</td>
<td>Lower Joints</td>
<td>S</td>
</tr>
<tr>
<td>Root Operation</td>
<td>Fusion</td>
<td>G</td>
</tr>
<tr>
<td>Body part</td>
<td>Toe Phalangeal Joint – Right</td>
<td>P</td>
</tr>
<tr>
<td>Approach</td>
<td>Percutaneous</td>
<td>3</td>
</tr>
<tr>
<td>Device</td>
<td>Internal Fixation Device</td>
<td>4</td>
</tr>
<tr>
<td>Qualifier</td>
<td>None</td>
<td>Z</td>
</tr>
</tbody>
</table>
Impacts to People

• Coders-learn new codes, increased queries
• Physicians-adopt new codes and ways of documenting
• Clinicians- clinical documentation enhancement
• Information Technology-more work
• Financial Management-learn new codes and reduced revenue cycle productivity
• payor Impact-adooption and claims processing challenges
• Others
Impacts to People

**PHYSICIANS**
- **Documentation**: The need for specificity dramatically increases by requiring laterality, stages of healing, weeks in pregnancy, episodes of care, and much more.
- **Code Training**: Code increases from 17,000 to 140,000. Physicians must be trained.

**NURSES**
- **Forms**: Every order must be revised or recreated.
- **Documentation**: Must use increased specificity.
- **Prior Authorization**: Policies may change, requiring training and updates.

**CLINICAL**
- **Patient Coverage**: Health plan policies, payment limitations, and new ABN forms.
- **Superbills**: Revisions required and paper superbills may be impossible.
- **ABNs**: Health plans will revise all policies linked to LCDs or NCDs, etc., ABN forms must be reformatted, and patients will require education.

**MANAGERS**
- **New Policies and Procedures**: Any policy or procedure associated with a diagnosis code, disease management, tracking, or PQRI must be revised.
- **Vendor and Payer Contracts**: All contracts must be evaluated and updated.
- **Budgets**: Changes to software, training, new contracts, and new paperwork will have to be paid for.
- **Training Plan**: Everyone in the practice will need training on the changes.

**LAB**
- **Documentation**: Must use increased specificity.
- **Reporting**: Health plans will have new requirements for the ordering and reporting of services.

**CODING**
- **Code Set**: Codes will increase from 17,000 to 140,000. As a result, code books and styles will completely change.
- **Clinical Knowledge**: More detailed knowledge of anatomy and medical terminology will be required with increased specificity and more codes.
- **Concurrent Use**: Coders may need to use ICD-9-CM and ICD-10-CM concurrently for a period of time until claims are resolved.

**BILLING**
- **Policies and Procedures**: All payer reimbursement policies may be revised.
- **Training**: Billing department must be trained on new policies and procedures and the ICD-10-CM code set.

**FRONT DESK**
- **HIPAA**: Privacy policies must be revised and patients will need to sign the new forms.
- **Systems**: Updates to systems may impact patient encounters.

Source: AAPC website
Impacts to Process

- Documentation practices
- Productivity and efficiency practices
- Contracts and business processes
- HIM practices
- Practice management processes
- Budget
- Payment conversions
- System logic and edits
- Claims edits
- Disease & Utilization management
Impacts to Process

Provider

- Providers Document Diagnoses
- Coders code primary dx, secondary dx, CCs & MCCs
- Patient is treated (ER, Radiology, etc)
- Coders determine procedure codes

Inpatient ICD Codes

- DRGs Diagnosis Related Groups
- APCs Ambulatory Payment Classifications

Outpatient or Professional HCPCS & CPT Codes

Payer

- Claim Gateway
- Pre-Process / Authorizations
- Pricing
- Benefits / Accumulators
- Analytics
- EOB Generation

Claim Payment

ICD-10 Impacts most processes for both Provider and Payer
Impacts to Technology

• IT system changes
• Upgrade software
• Modified field lengths
• Modified system logic
• Update superbills/encounter forms and databases
• Data reporting elements
• Submitting ICD-9 and ICD-10 codes
• Retain access to historical coded data in ICD-9 format
# Revenue Cycle Impacts

<table>
<thead>
<tr>
<th>Business Process/Patient Access</th>
<th>Patient Access Services</th>
<th>Charge/Coding Integrity</th>
<th>Patient Financial Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduling</td>
<td>Registration</td>
<td>Coding Assignment</td>
<td>Claims Processing</td>
</tr>
<tr>
<td>Pre-Registration</td>
<td>Financial Counseling</td>
<td>Pricing</td>
<td>Account Resolution</td>
</tr>
<tr>
<td>Registration</td>
<td>Clinical Intervention</td>
<td>Clinical Doc.</td>
<td>Payment Posting</td>
</tr>
</tbody>
</table>

- **Test Order “Optional”**

**IT Applications**

- Scheduling
- Patient Accounting
- Utilization Management
- Case Management
- Performance Measurement
- Claims Clearinghouse
- Patient Accounting
- HIS (including CPOE)
- HIM

---

- **Medium Impact to process and training**
- **Large impact to process and training**
Scheduling

• Scheduling systems can have fields for diagnostic (ICD-10) & procedure (CPT) entry
• Medical Necessity requirements
• Most scheduling is done through outside providers (physician offices)
  – They must provide the detail behind the reason for admission/clinical visit
• Coordinate with their systems for readiness
# Physician Practice Impacted

<table>
<thead>
<tr>
<th>Medical Office Staff</th>
<th>Touch-Points</th>
<th>ICD-10-CM Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receptionists</td>
<td>Check-in</td>
<td>IT systems</td>
</tr>
<tr>
<td></td>
<td>Check-out</td>
<td>Internal tools</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ICD-10-CM E&amp;T (functional)</td>
</tr>
<tr>
<td>Providers</td>
<td>Treatment areas</td>
<td>IT systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Internal tools</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ICD-10-CM E&amp;T (provider-level)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MR documentation overview, such as CDI</td>
</tr>
<tr>
<td>Ancillary Clinical Staff</td>
<td>Treatment areas</td>
<td>IT systems</td>
</tr>
<tr>
<td></td>
<td>Laboratory</td>
<td>Internal tools</td>
</tr>
<tr>
<td></td>
<td>Nurse’s/Scribe’s Stations</td>
<td>ICD-10-CM E&amp;T (provider-level or functional)</td>
</tr>
<tr>
<td></td>
<td>Transcription</td>
<td></td>
</tr>
<tr>
<td>Coding/Billing Staff</td>
<td>Coding/Billing Dept.</td>
<td>IT systems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Internal tools</td>
</tr>
<tr>
<td>Coding/Billing Staff</td>
<td>Third Party Interface</td>
<td>ICD-10-CM E&amp;T (in-depth)</td>
</tr>
<tr>
<td>A/R Mgmt. &amp; Collections</td>
<td>Manager; Collections</td>
<td>IT systems</td>
</tr>
<tr>
<td>IT/IS Interface</td>
<td>Manager</td>
<td>IT systems</td>
</tr>
</tbody>
</table>

Pre-Registration/ Registration

• Both pre-registration and registration are usually the same module
• Focus is primarily demographics
• Modules have English texts for entry of “simple” information
• English descriptive cross-walks (by specialty) are recommended
• Need to build (focusing on clarification)
Contract Management and Insurance Verification

- Building coverage patterns from TPP contracts
- Specific specialty definitions of both CPT and diagnosis (Case Rates)
- HIPAA Transaction sets
- Educating and Training staff for optimum coverage in identifying both POA and principal reason for admission (medical necessity)
- TPP systems monitoring
ICD-10 Effect on Payor Reimbursements

• Independent analysis of some of the most common reimbursement arrangements identified conversion challenges that may modify some payor and provider reimbursement arrangements, while for others the effect will be minimal.

• Solutions to these situations need to be tailored to your specific environment; however, you will want to review the possibilities identified in the analysis outlined in the table below.

• In cases such as diagnosis-related group carve outs where codes have a relatively small impact on reimbursement formulas, most payors will likely experience few conversion problems.
ICD-10 Impact on Payor Reimbursements

<table>
<thead>
<tr>
<th>Common Reimbursement Arrangements</th>
<th>Potential ICD-10 Impact Identified by Independent Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRGs and other case rates</td>
<td><strong>Hospitals, government, and commercial payors</strong>&lt;br&gt;<strong>Code focus: ICD-9 and procedure codes</strong>&lt;br&gt;1. ICD-9 diagnosis and procedure codes are the basis for diagnosis-related groups (DRG) classifications. 2. Using General Equivalence Mappings (GEMs), a number of ICD-10 codes did not map easily to the MS-DRGs (inpatient reimbursement); the clinical review process was required to complete the conversion process. GEMs are a tool to help find matches between ICD-9 and ICD-10 codes. 3. The ICD-10 MS-DRGs will likely produce some different reimbursement results compared to ICD-9-based MS-DRGs, for example: a. Clean mapping problems b. Service frequency, billed code volume, impact on dollars c. Clarity of ICD-10 code may produce a different code assignment based on the original ICD-9 code d. Dollar and volume magnitude related to the changes to Complications Comorbidities (CC)/ Major Complications Comorbidities (MCC) lists are unknown 4. The Inpatient Psychiatric Facility Prospective Payment System for psychiatric facilities and Medicare Severity Long-term Care DRG for long-term hospitals both use the same MS-Grouper and will be similarly affected. 5. When applying CMS-designed ICD-10 MS-DRGs to a commercial population, the case mix may vary more than the Medicare population does.</td>
</tr>
</tbody>
</table>
# ICD-10 Impact on Payor Reimbursements

<table>
<thead>
<tr>
<th>Common Reimbursement Arrangements</th>
<th>Potential ICD-10 Impact Identified by Independent Analysis</th>
</tr>
</thead>
</table>
| **Risk-adjusted Reimbursement**   | *Medicare/Medicaid programs Code focus: Hierarchical Condition Categories (HCCs) and Rx-HCCs*  
1. Although more than 5,500 ICD-9 diagnosis codes on the HCC and Rx-HCC models have no ICD-10 map, HCC developers will be able to include the conditions in the ICD-10 HCC without altering the intent. The largest potential impact is that more than 1,000 HCC ICD-9 codes have more than one ICD-10 option.  
2. The ICD-10 transition impact will be quite evident in situations where one ICD-10 code maps to more than one ICD-9 code and either the ICD-9 codes do not map at all to a HCC, or to the same HCC. |
| **DRGs/inpatient care rate carve-out, pass-through or add-on technology procedure or diagnosis** | *Commercial insurers Code focus: DRG inpatient payment carve-outs where payment is negotiated*  
1. Diagnoses carve-outs are typically paid by broad category with little reliance on coding specifics to differentiate payment levels.  
2. Expect minimal impact on procedural coding because inpatient patient carve-out procedures and technology are often reimbursed as a percentage of charges. Outpatient procedures are reimbursed based on Current Procedural Terminology (CPT) codes where additional information is not needed to pay a claim. |
| **Episode-based Reimbursement**   | *Demonstrations (ACE – Acute Care Episode) and other pilots*  
*While there have not been many systems reimbursing on episodes of care based on ICD-9 codes, the advent of ICD-10-specific codes will likely accelerate the development of these payment types.* |
# ICD-10 Impact on Payor Reimbursements

<table>
<thead>
<tr>
<th>Common Reimbursement Arrangements</th>
<th>Potential ICD-10 Impact Identified by Independent Analysis</th>
</tr>
</thead>
</table>
| **Performance-based Reimbursement** | *Health plans, Medicare Pay for Performance (P4P)*  
*Code focus: Healthcare Effectiveness Data and Information Set (HEDIS) and similar performance measures*  
1. The most common structures are based on either reaching specified performance level or degree of improvement. The transition to ICD-10 may affect HEDIS-based outcomes as HEDIS uses ICD-9 diagnosis and procedure codes along with other codes such as CPT and revenue codes. In the case of immunization codes, ICD-9 codes are more specific than the ICD-10 mapping (five ICD-9 codes would now map to two ICD-10 procedure codes). Because these ICD-10 codes are less specific, the small portion of immunizations occurring in an inpatient setting will be unidentifiable under ICD-10, and this may affect performance measurement. |
| **Hospital Billed Charges** | *Hospitals*  
*Code focus: billed charges, CPT/HCPCS*  
1. The conversion to ICD-10 should have minimal impact on billed charges because predecessor ICD-9 codes were not used to create the charges. |
| **Usual and Customary Reimbursement (UCR)** | *Payors, hospitals, and providers*  
*Code focus: diagnosis codes*  
1. Diagnosis codes are used to help determine the payment rate and facilities’ qualification as inpatient rehabilitation facilities (IRFs). Therefore, the initial conversion to ICD-10 will have some impact on reimbursement based on IRF-Prospective Payment System (PPS). The challenge will be in determining which ICD-10 codes are the qualifying codes that should be included in the IRF logic.  
2. The increased specificity of ICD-10 codes will influence the IRF-PPS model in the future. |
# ICD-10 Impact on Payor Reimbursements

<table>
<thead>
<tr>
<th>Common Reimbursement Arrangements</th>
<th>Potential ICD-10 Impact Identified by Independent Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Reimbursement Arrangements</td>
<td>Brief summary</td>
</tr>
<tr>
<td></td>
<td>Resource Utilization Groups (RUGs): Minimal if any impact on skilled nursing facilities and RUGs.</td>
</tr>
<tr>
<td></td>
<td>Home Health Resource Groups (HHRGs): Although many of the HHRG diagnostic categories are broad, there will be some instances where HHRG assignment for the same condition may vary under ICD-10 compared to ICD-9 diagnosis codes.</td>
</tr>
<tr>
<td></td>
<td>Possible future conversion of the CPT/HCPCS codes to ICD-10 PCS parallel with the CPT/HCPCS codes.</td>
</tr>
</tbody>
</table>

Example of Crosswalk DRG Weight Implications

The use of different crosswalks by individual health plans may result in different levels of reimbursement for the same set of ICD-10 diagnosis and procedure codes.

Source: Deloitte Consulting presentation “Do Not Underestimate ICD-10’s Impact on Population Health Management” at the Forum 10 in Washington, DC 10/15/10
## Examples of I-9 to I-10 Conversions

<table>
<thead>
<tr>
<th>Crohn’s Disease</th>
<th>ICD – 9 (4)</th>
<th>ICD – 10 (28)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional enteritis of small intestine</td>
<td>555.0</td>
<td>K50.00</td>
</tr>
<tr>
<td>Regional enteritis of large intestine</td>
<td>555.1</td>
<td>PLUS an</td>
</tr>
<tr>
<td>Regional enteritis of small intestine w/ large intestine</td>
<td>555.2</td>
<td>ADDITIONAL</td>
</tr>
<tr>
<td>Regional enteritis of unspecified site</td>
<td>555.9</td>
<td>27 CODES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD – 9 92.27</th>
<th>ICD-10 PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation or insertion of radioactive elements</td>
<td>261 PCS codes for Anatomical sites specified 21 distinct Approaches</td>
</tr>
</tbody>
</table>
## MCC/CC Category Conversion

<table>
<thead>
<tr>
<th>Conversion Summary</th>
<th>MCC</th>
<th>CC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM Codes on List</td>
<td>1,592</td>
<td>3,427</td>
<td>5,019</td>
</tr>
<tr>
<td>ICD-10 CM codes Auto-translated</td>
<td>3,152</td>
<td>13,594</td>
<td>16,845</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
<th># ICD-9 codes</th>
<th># ICD-10 codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>291-293</td>
<td>Heart Failure &amp; Shock</td>
<td>27</td>
<td>20</td>
</tr>
<tr>
<td>231-236</td>
<td>Coronary Bypass</td>
<td>9</td>
<td>232</td>
</tr>
<tr>
<td>250-251</td>
<td>Percutaneous Cardiovascular Procedure without Stent</td>
<td>8</td>
<td>136</td>
</tr>
<tr>
<td>258-259</td>
<td>Cardiac Pacemaker Device Replacement</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>533-534</td>
<td>Fracture of Femur</td>
<td>14</td>
<td>273</td>
</tr>
</tbody>
</table>
Clinical Quality Management

• Education and Training will be BIGGEST situation for specificity requirements

• Not JUST providers, nurses and coders
  – Physician office staff
  – Patient/physician office medical record
  – Hospital Electronic Medical Records (EHR)
  – Practice Management systems
  – “Outsourcing” Labs, Radiology, Oncology, etc.
How ICD-10-CM Affects Clinical Documentation

• The increased code detail contained in ICD-10-CM means that clinical documentation will need to change substantially. The ICD-10-CM includes a more robust definition of severity, comorbidities, complications, sequelae, manifestations, causes, and a variety of other important parameters that characterize the patient’s conditions.

• A large number of ICD-10-CM codes only differ in one parameter. For example, nearly 25 percent of the ICD-10-CM codes are the same except for indicating the right side of the patient’s body versus the left. Another 25 percent of the codes differ only in the way they distinguish among “initial encounter,” versus “subsequent encounter,” versus “sequelae.”

• For example, even though there are more than 1,800 available codes for coding fractures of the radius, there are only approximately 50 distinct recurring concepts. The next slide shows the type of documentation the ICD-10-CM will require for a fracture of the radius and includes the following:

  – **Category**: The category for the medical concepts that will need documentation

  – **Documentation Requirements**: The list of individual concepts that should be considered in documentation to support accurate coding of the patient conditions

*Source: CMS’ ICD-10 Implementation Guide for payors*
## Sample Documentation Requirements for Fractures of the Radius

<table>
<thead>
<tr>
<th>Category</th>
<th>Documentation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fracture Type</strong></td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>Torus (Buckle) Fractures</td>
</tr>
<tr>
<td>Closed</td>
<td>Green Stick Fractures</td>
</tr>
<tr>
<td>Pathologic</td>
<td>Stress Fractures</td>
</tr>
<tr>
<td>Phsyseal (Growth Plate) Fractures</td>
<td>Orthopedic Implant (fractures associated with) Bent Bone</td>
</tr>
<tr>
<td>Neoplastic Disease</td>
<td></td>
</tr>
<tr>
<td>Torus (Buckle) Fractures</td>
<td></td>
</tr>
<tr>
<td>Green Stick Fractures</td>
<td></td>
</tr>
<tr>
<td>Stress Fractures</td>
<td></td>
</tr>
<tr>
<td>Orthopedic Implant</td>
<td></td>
</tr>
<tr>
<td><strong>Healing</strong></td>
<td></td>
</tr>
<tr>
<td>Routine</td>
<td>Nonunion</td>
</tr>
<tr>
<td>Delayed</td>
<td>Malunion</td>
</tr>
<tr>
<td><strong>Localization</strong></td>
<td></td>
</tr>
<tr>
<td>Shaft</td>
<td>Head</td>
</tr>
<tr>
<td>Lower End</td>
<td>Neck</td>
</tr>
<tr>
<td>Upper End</td>
<td>Styloid Process</td>
</tr>
<tr>
<td><strong>Encounter</strong></td>
<td></td>
</tr>
<tr>
<td>Initial</td>
<td>Sequelae</td>
</tr>
<tr>
<td>Subsequent</td>
<td></td>
</tr>
<tr>
<td><strong>Displacement</strong></td>
<td></td>
</tr>
<tr>
<td>Displaced</td>
<td>Nondisplaced</td>
</tr>
<tr>
<td><strong>Classification</strong></td>
<td></td>
</tr>
<tr>
<td>Salter Harris I</td>
<td>Salter Harris IV</td>
</tr>
<tr>
<td>Salter Harris II</td>
<td>Gustilo Type I or II</td>
</tr>
<tr>
<td>Salter Harris III</td>
<td>Gustilo Type IIIA, IIIB, or IIIC</td>
</tr>
<tr>
<td><strong>Laterality</strong></td>
<td></td>
</tr>
<tr>
<td>Right</td>
<td>Unilateral</td>
</tr>
<tr>
<td>Left</td>
<td>Bilateral</td>
</tr>
<tr>
<td>Unspecified Side</td>
<td></td>
</tr>
<tr>
<td><strong>Joint Involvement</strong></td>
<td></td>
</tr>
<tr>
<td>Intra-articular</td>
<td>Extra-articular</td>
</tr>
<tr>
<td><strong>Fracture Pattern</strong></td>
<td></td>
</tr>
<tr>
<td>Transverse</td>
<td>Comminuted (many pieces)</td>
</tr>
<tr>
<td>Oblique</td>
<td>Segmental</td>
</tr>
<tr>
<td>Spiral</td>
<td></td>
</tr>
<tr>
<td><strong>Named Fractures</strong></td>
<td></td>
</tr>
<tr>
<td>Colles’</td>
<td>Barton’s</td>
</tr>
<tr>
<td>Galleazzi’s</td>
<td>Smith’s</td>
</tr>
</tbody>
</table>
Clinical Quality Management

• Start with “simple” tasks
  – Choose a major specialty (volunteer)
  – Transform a super bill as a specific example
  – Physical “Body Sheets” for levels of specificity
  – Complete and then get assessment

• Start some informative sessions to discuss people, process and technology
Charge Capture and CDM

• Will order entry screens change?
• Will charge capture forms change?
• Modifiers for hard codes can become CRITICAL
  – 76, 77, 24
  – Physicians time
• Prime concern are “feeder” systems such as:
  – Laboratory
  – Radiology
  – Surgery
  – Specialty Clinics
  – Interfaces from ALL systems
Medical Records Documentation

- Education and Training for specificity requirements
- EMR with ‘drop down’ boxes for “choice”
  - CMS is monitoring levels from EMR
- Consider/re-consider/support concurrent review with trained nurses/coders
- Dictation and transcription training for specificity
Inpatient and Outpatient Coding

• Medical Necessity for:
  – Physician Orders
  – Ancillary Review
  – Admissions Review

• Concurrent review processes

• “System” support from vendors ($$$)
  – CodeAssist; TruCode; others

• Independent education and training

• Interview and assess staff for re-certification
Claim Generation and Submission

- **Main Vendor System**
  - Review of each module

- **Ancillary Support Systems**
  - Ancillary areas
  - Clearinghouses
  - IT for HIPAA transactions
  - Bank for EFT, 835, etc.
Claim Generation and Submission

• All third party insurance “systems” for monitoring, tracking, testing, etc.

• State systems must also be monitored, tracked and tested for Medicaid, Medicaid managed care, DOH, State Insurance Department, etc.

• Start inquiry NOW (10/1/13) on State & Federal Exchange requirements and electronic interchange
Third Party Follow Up

• Critical piece for staff in preventing delays from TPP due to their system issues, etc.

• Critical piece in follow up due to the expectation that many TPPs will delay with a “medical review” statement

• Follow up staff need an internal resource list of other departmental decision makers for quick turnaround response to TPP
Payment Posting

• Electronic and/or manual patient account posting may not have a critical ‘play’ with ICD10 but...
  – EOBs need to be monitored more closely due to expectation/expansion of underpayments in the reconciliation of contract terms to submitted claim data
  – DRG cross-walk still in discussion due to major ICD category shifts and major additions to PCS
Payment Posting

• Referencing BACK to Contract Management, some considered options for negotiations are:
  – Setting up “scheduled” payments rather than claim specific (reconcile quarterly)
  – Modify inpatient contracts to ‘per diem’ until DRGs are adjusted to new system
  – Modify outpatient contracts to ‘percent of charge’ or eliminate ICD support of ‘case rate’
  – Consider bundling of selected services with no diagnostic challenge
  – Consider value-based purchasing based on case mix adjustments and code specificity
Denial Management

• Expectation of increase in this area due to computer system changes, data interchange specs, cross-over between payors, etc.
• Increase may not be due to contractual error
• Define medical necessity requirements for each payor
• Reconcile InterQual criteria with Milliman since these will be re-written based upon ICD-10 criteria
  • Comparative will be helpful
Denial Management

• Will require ‘assertive’ staff since TPPs will be training their staff to lengthen the process
• Monitor TPP experience closely and document behavior patterns
• Obtain a contact with BBB and State Insurance Department for interchange of information regarding patterns of denial
Appeals

• Expectation of an increase in “peer-to-peer” reviews
• Documentation support extremely important with accurate specificity
• Initial development of “appeals sheet” with appropriate levels of requirements will help providers and nursing to improve Appeals process
• Outsourcing “may or may not” be an answer
Final Resolution

• Final Resolution is Final Resolution
• However, using the “lessons learned” approach, one should examine
  – Underpayment challenges
  – TPP behavior patterns
  – Major denial reasons
  – Success ratios
  – Each of your payor conversion strategy
Payor Perspective

People

- Clinicians and medical reviewers will need to be fluent in both ICD-9 and ICD-10
- Training will be critical

Process

- Medical policy will require an overhaul
- Organizations will have to invest the time to define how it will stratify ICD-10 codes for medical and reimbursement requirements

Technology

- Pre-Cert and Approval systems will need to be able to record both code sets
- There will not be a single cross-walk solution

There are no holy grail crosswalks – Each Health Plan needs to decide for themselves how ICD-10 is interpreted in regard to medical necessity

Source: Deloitte Consulting presentation “Do Not Underestimate ICD-10’s Impact on Population Health Management” at the Forum 10 in Washington, DC 10/15/10
Payor Implementation Impacts

- According to CMS there are 4 HIPAA compliant strategies that payors may employ:
  1. Crosswalk Strategy
  2. Minimum Upgrade Strategy
  3. Maximum Upgrade Strategy
  4. Upgrade and Crosswalk Hybrid Strategy
- Keep a log of each payor’s approach
# Implementation Strategy Options for Payors

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crosswalk Strategy</td>
<td>Transform inbound ICD-10 business transactions to the ICD-9-CM equivalent using reimbursement mappings or crosswalks. Business processes and systems would continue to store ICD-9-CM codes and use ICD-9-CM rules, without full conversion to ICD-10 codes. This approach does not require updates to internal policies, processes, or systems to accommodate ICD-10 codes.</td>
<td>Lower initial ICD-10 implementation costs Less initial disruption to business operations and systems</td>
<td>Payor may not be positioned to take advantage of ICD-10’s benefits ICD-10 implementation will be more difficult and costly in the future Difficulty associating ICD-10 code submitted by external partner to information stored in Payor systems Loses specificity of ICD-10 codes and their added benefits Will have to undergo another transition for full ICD-10 adoption</td>
</tr>
</tbody>
</table>
## Implementation Strategy Options for Payors

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Upgrade Strategy</td>
<td>Convert SOME policies, processes, and systems to ICD-10 using the General Equivalence Mappings (GEMs) tool. The Payor translates policies and processes PARTIALLY by equivalent aggregation. Accept, store, and process ICD-10 transactions from business partners. Update business rules to use SOME added detail of ICD-10. Translate ICD-9-CM business rules and policies to ICD-10 without taking into consideration the full potential benefits of ICD-10.</td>
<td>Upgrade Payor systems to meet minimum business functionality Potential for fewer future transitions than the crosswalk strategy</td>
<td>Does not gain all of ICD-10 benefits Will need to upgrade in the future to fully use ICD-10</td>
</tr>
</tbody>
</table>

Source: CMS' ICD-10 Implementation Guide for Payors
# Implementation Strategy Options for Payors

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| Maximum Upgrade Strategy| Convert ALL policies, processes, and systems to ICD-10 using the GEMs tool. The Payor translates policies and processes FULLY by equivalent aggregation.  
Accept, store, and process ICD-10 transactions from business partners.  
Update ALL business rules in claims adjudication to use the added detail of ICD-10.  
Translate ICD-9-CM business rules and policies to ICD-10, taking into consideration the full potential benefits of ICD-10.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Positions Payor to benefit from ICD-10  
No later conversions required so future costs are reduced  
Payor can pay more accurately based on the greater specificity of ICD-10 codes  
Improved reporting and historical data files                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Initial development costs might be higher                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
## Implementation Strategy Options for Payors

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
</table>
| Upgrade and Crosswalk Hybrid     | Converts highly affected or frequently referenced policies, processes, and systems to ICD-10 using the GEMs tool. Uses an ICD-10 to ICD-9 crosswalk for claims with ICD-10 codes that do not fall into the costly or frequently used category.   | Lower initial cost than optimal compliance  
Gains some ICD-10 benefits                                                                                       | Difficult to determine which systems should be updated to ICD-10  
Difficult to identify all data interrelationships at the beginning of process  
Will need to transition the rest of the policies, processes, and systems at a later date |
| Strategy                          |                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                           |                                                                                                                                                                                                           |

*Source: CMS' ICD-10 Implementation Guide for Payors*
ICD-10 Facilitates Payor Initiatives

Health Plans can benefit from compliance and use it as a tool to emphasize methods that incentivize providers to improve quality and cost efficiencies.

The primary purpose of ICD-10 is to improve clinical communication:

- Enhance Pay for Performance
- Enhance Comparative Effectiveness
- Enrich Disease Management Policies
- Improved Quality and Coordination of Care
- Facilitate Fraud and Abuse Detection
- Improved Account Informatics
- Improved provider performance reporting and tiering

As Medicare and Medicaid payers move providers into enhanced payment modalities, commercial plans will soon be able to reap the benefit of this change.

ICD-10 becomes a catalyst for Platform Modernization which can improve through-put and reduce PMPM costs.

ICD-10 was not designed to revolutionize payment or reimbursement; however, it can enable reimbursement methodologies that will more accurately reflect patient status and care.

Source: Deloitte Consulting presentation “Do Not Underestimate ICD-10’s Impact on Population Health Management” at the Forum 10 in Washington, DC 10/15/10
## Potential for Healthcare Provider Impacts and Risks Summary

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>RISKS</th>
<th>RESULTS</th>
<th>RESOLUTION</th>
</tr>
</thead>
</table>
| Better documentation for profiles, billing and research | Incomplete documentation; Lower clinical delivery rate | Physician queries delay billing an increase DNFB | Physicians must be retrained  
Clinical Documentation Improvement vital |
| Great reduction in nonspecific coding | Training & productivity challenges | Decreased coding productivity an increase DNFB;  
Increase in claims error rate;  
High training costs;  
Coder turnover | Educate coders over time  
Train a Trainer  
Individually address coder issues  
Train billers |
| Clearer code choices | Software issues | Encoder and/or abstracting software does not support both ICD-9 and ICD-10 code fields;  
Costs for hardware conversion | Communicate with vendors early  
Budget for hardware and software expenses  
Spend time testing |
| Operational efficiencies for more efficient claims processing | Coding errors & payor contract management | Higher claims error rate leads to billing delays and lower cash;  
Less accurate data for reimbursement trends | Work with payors to assess coding  
conversion payment plans  
Perform gap analysis coding with both ICD-9 and ICD-10 |
Snapshot of ICD-10 Impact Across Healthcare Functional Areas

**ADMINISTRATION**
- Compliance
- Risk Management
- Vendor/Trading Partners Relationships & Contracts
- Contingency Planning
- Finance (e.g. Fiscal Well-being)

**PATIENT REGISTRATION**
- Registration and Scheduling Systems
- Advance Beneficiary Software
- Performance Measurement Systems
- Medical Necessity Edits

**BILLING**
- Financial Systems
- Billing Systems
- Claim Submission Systems
- Compliance Checking Systems
- System Logic and Edits
- National & Local Coverage Criteria
- Conversion of Other Payment Methods
- DRG Grouper

**HEALTH INFORMATION MANAGEMENT (HIM)**
- Encoding Software
- Abstracting System
- DRG Grouper
- Compliance Software
- Medical Records Abstracting
- Training of Coders

**CLINICAL SYSTEMS**
- Clinical Protocols
- Orders (tests) System / Clinical Systems
- Clinical Reminder System
- Medical Necessity Software
- Disease Management System
- Decision Support System
- Pharmacy System

**SUPPORT SYSTEMS**
- Class Mix System
- Utilization Management
- Quality Management
- Case Management

**REPORTING**
- Provider Profiling
- Fraud Management
- Quality Measurement
- Utilization Management
- Disease Management Registries
- Other Registries

**INFORMATION TECHNOLOGY**
- Electronic Data Interchange (EDI)
- Project Management Methodology
- Testing
- Software and Hardware upgrades, if required
- And so much more.

Source: Slide adapted by The Kiran Consortium Group LLC from an original slide created by Dwan Thomas-Flowers, MBA, RHIA, CCS, Mayo Clinic, Jacksonville, FL – Presentation: ICD-10’s Impact on Coding Operations: Practical Insights for Senior Leaders.
Immediate Internal Projects

• **Crosswalk Preparation**
  - Continue to evaluate the effect on data analysis. Run ICD-9 DRGs thru GEMS now for DRG changes by payor. Review data collection tools for ICD-10 specificity opportunities.
Immediate Internal Projects

• Clinical Documentation Improvement
  – Continue assessing CDI practices
    • evaluate medical record documentation
    • collaborate with physicians
    • generate pocket ‘reference’ cards
Immediate Internal Projects

• Denial Management Strategy
  – Run various reports to identify most common medically necessary denials; admission denials; authorization denials.
Immediate Internal Projects

• Impact Assessments
  – Continue and initiate resolutions with all payors, providers, system vendors and EDI trading partners.
Immediate Internal Projects

Develop Coding Mitigation Plan

- Work through scenarios to prevent decreased coding productivity and accuracy.
- Is there a need for contracted outsource vendor assistance? If so- contract now because there is a short supply.
Immediate Internal Projects

• Reserve Cash
  – With anticipated delays and incorrect reimbursements, cash flow will be interrupted and increased labor costs to manage the influx of follow-up needs will require liquidity.
Outsource Partner Considerations

**Education and Training**

- Educating providers and staff on documentation requirements is a MUST to assure quality of data for compliant coding.
- Training should be delivered at the right time; if you deliver it too early, people forget and then they're not interested. And if you're too late, providers run the risk that their employees won't have the time to internalize it.
Outsource Partner Considerations

• **Financial Modeling**
  
  — Forecasting the impact of "flipping the codes" will have on both payors and providers is a specialized skill-set often not available at a provider setting. How will this factor on payor reimbursements or your medical loss ratio?

*Don’t Let ICD-10 Break the Bank*
Outsource Partner Considerations

• Organizational Readiness.
  – This includes taking a comprehensive look at the organization to determine not only how prepared it is for ICD-10, but how likely it is to see success after the transition.
  – Outsourcing this aspect of the transition offers another pair of eyes to assess the organization as a whole
Outsource Partner Considerations

• Accounts Receivables
  – Going live with ICD-10 will be akin to a system conversion. There may be a cost benefit to your organization by selling your receivable from a specified date allowing staff increased time to focus on the anticipated chaotic payor responses to your claims.
## Additional Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Service(s) Provided</th>
<th>Stakeholders</th>
</tr>
</thead>
</table>
Developed in Excel. Helps users understand the impact of ICD-10 in four key areas: coding, revenue cycle, project management, and information technology.                                                                                                   | Health care providers and Payor organizations          |
| HIMSS ICD-10 Playbook                                                  | Provides a rich, well-structured index to a variety of white papers and other resources from a variety of organizations.                                                                                                                                                                                                                         | All stakeholders                                    |
| American Medical Association (AMA) – educational Resources               | A series of resources/artifacts to help physicians implement ICD-10-CM into their practices:  
-ICD-10 Fact Sheets  
-ICD-10 Project Plan Template  
-ICD-10 Checklist  
Provides links to other associations and specific resources tailored to physicians’ needs.                                                                                                                                                                                                 | Physician practices, Payor organizations            |
| American Academy of Professional Coders (AAPC) – ICD-10 Code Translator | Compares ICD-9 to ICD-10 codes. (Note: this tool only converts ICD-10-CM codes, not ICD-10-PCS)                                                                                                                                                                                                                                           | Medical coders                                     |
| Workgroup for electronic Data Interchange (WeDI) – Vendor Resource Directory and other resources | Provides an assortment of white papers related to ICD-10.  
Listservs and conference calls on various subject areas allow collaboration among different parts of the industry.                                                                                                                                                                                                                     | All stakeholders                                    |
Questions

Rob Borchert
President
Best Practice Associates
rob@bpa-consulting.com
(315) 345-5208

Lorrie Borchert
President
Best Practice Training Institute
lorrieborchert@me.com
(540) 226-2034