ICD-10: Keeping Track of the Moving Target

John Woerly, RHIA, MSA, CHAM, FHAM
Senior Principal – Accenture
john.woerly@accenture.com
OUTLINE

• Session Objectives
• ICD-10 Overview
• Operational Impacts
• Summary
• Questions
SESSION OBJECTIVES

The objectives of this session are to provide participants with:

• an overview of ICD-10

• an understanding of the diverse impact of ICD-10 in terms of People, Process and Technology

• an overview of how Revenue Cycle operations (Patient Access, HIM & Patient Financial Services) will be impacted

• an opportunity to gain successful operational ideas from this case study, as well as from other participants in a group discussion
**What is ICD-10?**

What does ICD-10-CM/PCS stand for?
International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System

What is the International Classification of Diseases?
The International Classification of Diseases is the international standard diagnostic classification used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records

Why is ICD Important?
This coding system is used worldwide for morbidity and mortality reporting and statistics, reimbursement, and decision support in the healthcare industry
In January 2009, the U.S. Department of Health and Human Services (HHS) finalized regulations to make modifications to medical data code set standards to adopt ICD-10-CM and ICD-10-PCS. (Rule: CMS-0013-F)

- ICD-10 was published in the mid-1990’s by the WHO and has been adopted by all industrialized countries except the U.S. (ICD-11 is planned to be released in 2015)
- ICD-10 is a fundamental change to the classification and categorization of diseases that incorporates much greater specificity and clinical information
- ICD-10-CM (Clinical Modification) and ICD-10-PCS (Procedure Coding System) have structural differences from ICD-9-CM/ICD-9-PCS to allow for more flexibility and a greater level of detail
- In August 2012, HHS released a final rule that officially delayed the ICD-10 compliance date from Oct. 1, 2013 to Oct. 1, 2014, partially to look at the incremental changes needed in reforming health care
In March 2014, the House & Senate voted on a measure to delay the 2014 ICD-10 compliance deadline, stating "The Secretary of Health and Human Service may not, prior to Oct. 1, 2015, adopt ICD-10 code sets as the standard for codes sets." It also cites sections in the Social Security Act and the Code of Federal Regulations, which contain the secretary's authority to mandate the new code sets. (Protecting Access to Medicare Act of 2014 – H.R. 4302)

- Without a single mention of ICD-10, the Senate has pushed back the compliance date for the next code set by a full year with the passing of legislation aimed at providing a one-year patch for the Sustainable Growth Rate (SGR), which focuses upon reimbursement cuts to physicians under the SGR formula.

- That doesn’t mean October 1, 2015, would be the new implementation date - the date could get pushed back to 2016 or 2017. It will also reignite the debate about whether we should just wait for ICD-11.

- The bill also mentions extending CMS’ reviews of the 2-midnight rule. A third extension would push the pre-payment status reviews out to March 31, 2015. The 2-midnight rule would still be in effect if the bill passes; however, if the review period is extended, it may allow facilities additional time to understand denials and implement policies related to the 2-midnight rule.

- President Barack Obama signed the SGR patch and ICD-10 delay in early April 2014.
The decision to further delay ICD-10 has met with mixed emotions and much controversy.

- CMS estimates that a one-year delay of ICD-10 could cost between $1 billion and $6.6 billion, according to American Health Information Management Association (AHIMA) blog post, which opposes the bill (iHealthBeat, 3/27)

- Many hospital CIOs have expressed concern over the delay of the ICD-10 deadline, noting the amount of training and funding that has been spent on the conversion, FierceHealthIT reports

- After the House vote, Medical Group Management Association (MGMA) senior policy adviser Robert Tennant said that the proposed delay is "recognition that the industry is simply not ready for the transition" (iHealthBeat, 3/27)

- A February poll by MGMA of providers shows that more than two-thirds remain deeply concerned about the financial and productivity impacts of the ICD-10 transition, highlighting worries over cost, technology upgrades, and clinical documentation improvement as major downsides to the 2014 timeline

- The AMA has also continued its fight against the new code set, claiming that its huge member base will suffer significant negative impacts if ICD-10 goes ahead as planned
OVERVIEW OF THE ICD-10 MANDATE
WHAT HAS BEEN THE REACTION? (CONTINUED)

• Despite the reassurance of an American Academy of Family Physicians (AAFP) survey of the major commercial payors, which claims that big health plans such as Aetna and Humana are ready to go, providers aren’t so sure that they will be able to successfully submit claims and receive timely and appropriate reimbursement.

• Medicare has been extremely unhelpful, in many providers’ eyes, by failing to open its arms for adequate end-to-end testing with the industry at large. The limited end-to-end pilot planned for the end of July 2014 may not be significant enough to give the majority of stakeholders a clear idea of what to do when ICD-10 rolls around.

• Distracted and frustrated by the process of certifying their EHR products for Stage 2 of Meaningful Use according to the new 2014 ONC criteria, not all software developers have been able to deliver on their ICD-10 promises to anxious providers.

• “While the delay does allow for additional time for preparation, it poses a significant financial and resource impact on entities that were heavily invested in the transition,” added the American Podiatric Medical Association (APMA) in a public statement.

• To date, HHS and CMS have kept tight-lipped about what they’re thinking, after stating over and over again that October 1, 2014 was a hard and fast deadline with no more possibility of a delay.
OVERVIEW OF THE ICD-10 MANDATE
DELAY IMPACT / STRATEGY GOING FORWARD

Where do you fall on the ICD-10 preparation spectrum?
Are you pleased with the prospect of a delay, or do you want to get it over with?

• Know where you are in the “spectrum” of implementation:
  – If you have been *aggressively pursuing* ICD-10 implementation, continue! Further expand Dual Coding, End-to-End Testing, and Revenue Neutrality efforts to next year, and basically be ready to “turn on the switch” come the new date
  – If you have been *more conservative* in your ICD-10 implementation efforts, use this time wisely! Use this time to plan for implementation. Potentially consider implementation of a new ICD-10 compliant system and sunset old systems and/or implement ICD-10 tools (e.g., Computer Assisted Coding, CDI work queues, etc.)

• Key areas to concentrate on include:
  – Clinical Documentation Improvement (CDI)
  – Dual Coding and Coder Recruitment
  – Training – Get HIM staff certified; Continue Physician training related to CDI
  – System Upgrades – ICD-10 tools
  – IT Remediation – Concentrate on vendors with problematic upgrades and continue remediation steps
  – End-to-End Testing – Develop scripts and test all systems
  – Revenue Neutrality – Payor Contracting and Testing

• Keep an eye on CMS notices and direction of next steps
**Once ICD-10 Moves Forward... What Does It Mean?**

*There will be significant changes to the structure, format and number of codes available to allow for more specificity.*

### Diagnosis Codes

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>ICD-9 Diagnosis</th>
<th>ICD-10 Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Set Name</td>
<td>ICD-9-CM Volumes 1 and 2</td>
<td>ICD-10-CM</td>
</tr>
<tr>
<td>Number of Codes</td>
<td>~ 14,000</td>
<td>~ 68,000</td>
</tr>
<tr>
<td>Number of Characters</td>
<td>3 to 5 Numeric (+ V &amp; E codes)</td>
<td>3 to 7 Alphanumeric</td>
</tr>
<tr>
<td>Format</td>
<td>XXX.XX</td>
<td>AXX.XXX X</td>
</tr>
</tbody>
</table>

- As of date of service 10/1/2014, all health care claims will be submitted to payors with diagnoses coded in ICD-10-CM for all provider types.

### Procedure Codes

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>ICD-9 Procedure</th>
<th>ICD-10 Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Set Name</td>
<td>ICD-9-CM Volume 3</td>
<td>ICD-10-PCS</td>
</tr>
<tr>
<td>Number of Codes</td>
<td>~ 4,000</td>
<td>~ 73,000</td>
</tr>
<tr>
<td>Number of Characters</td>
<td>3 to 4 Numeric</td>
<td>7 Alphanumeric</td>
</tr>
<tr>
<td>Format</td>
<td>XXX.XX</td>
<td>AXX.XXX X</td>
</tr>
</tbody>
</table>

- As of date of service 10/1/2014, health care claims will be submitted to payors with procedures coded in ICD-10-PCS for hospital inpatient services only.
- CPT and HCPCS codes will continue to be used for professional claims and outpatient services.
The ICD-10 code set is a full replacement of the ICD-9 code set that will provide additional granularity for diagnosis and procedure codes. This additional granularity is the primary driver of value.

An Example of Structural

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Category</td>
<td>Etiology, anatomic site, manifestation</td>
</tr>
</tbody>
</table>

An Example of One ICD-9 code being Represented by Multiple ICD-10 Codes

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>ICD-10 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>25061</td>
<td>E1040, E1041, E1044, E1049</td>
</tr>
</tbody>
</table>

Diabetes mellitus with neurological manifestations type I not stated as uncontrolled

Type 1 diabetes mellitus with diabetic neuropathy, unspecified
Type 1 diabetes mellitus with diabetic mononeuropathy
Type 1 diabetes mellitus with diabetic amyotrophy
Type 1 diabetes mellitus with other diabetic neurological complication

The industry expects that mapping ICD-9 and ICD-10 codes will be a complex task
**UNIVERSAL BENEFITS OF ICD-10**

*ICD-10 incorporates much greater specificity and clinical information to improve capture of healthcare information, which has multiple benefits.*

- Greater coding accuracy and specificity
- Higher quality information for measuring healthcare service performance (quality, safety, efficiency), outcome analysis, cost analysis and monitoring of resource utilization
- Improved efficiencies and lower costs
- Reduced coding errors
- Greater achievement of the benefits of an electronic health record
- Recognition of advances in medicine and technology
- Alignment of the US with coding systems worldwide
- Improved ability to track and respond to international public health threats (e.g. SARS, H1N1)
- Enhanced ability to meet HIPAA electronic transaction/code set requirements
- Increased value in the US investment in SNOMED-CT
- Space to accommodate future expansion

*Source: AHIMA Website – http://www.ahima.org/icd10/value-icd-10.html*
**Impact of NOT Implementing ICD-10**

*Failing to meet the ICD-10 deadline to transition to the ICD-10 medical code set could have serious fiscal and reporting consequences*

- CMS will no longer accept the ICD-9 code set for services provided on or after ICD-10 compliance deadline date. Failure to fully transition to the ICD-10 code set will result in loss of CMS revenue.
- Non-compliance with Outpatient Code Edits, including Medical Necessity Edits.
- Inaccurate / incomplete clinical metrics and pay-for-performance reporting that does not meet peer standards.
- Loss of contracts / elongated contract negotiations for renewals.
- Erroneous quality reporting to regulatory and third party agencies:
  - Joint Commission core measures
  - National Quality Forum endorsed measures
  - Physician Consortium for Performance Improvement (PCPI) measures
  - CMS demonstration projects
  - CMS Hospital Acquired Conditions DRG impact
  - State data reporting
- Inaccurate / Incomplete cost management reporting.
- Potential adverse impact on clinical workflows / patient care referrals generated from clinical data.
OPERATIONAL IMPACT IS PROJECTED TO BE HIGH

Implementation costs are estimated to range from “50-100% more than HIPAA” to “3 to 4 times more than HIPAA”


• Provider experience in other countries showed an initial doubling of days in accounts receivable and an initial 50% reduction in coder productivity (first 6 months)

• Because of the implementation of ICD-10-PCS as well as more advanced use of EHR systems, the US implementation effort will be far more complex and difficult than it was for other countries

• Significant changes will be required in:
  – Technology platforms
  – Clinical documentation (training for staff and providers)
  – All reports, dashboards and solutions that use diagnostic and billing data
## Operational Impact Based Upon an Industry Study

<table>
<thead>
<tr>
<th></th>
<th>Coder Productivity</th>
<th>Physician Productivity</th>
<th>Rework Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3-12 Mos. Post-Transition</strong></td>
<td>-20%</td>
<td>-5% to -10%</td>
<td>-10% to -25%</td>
</tr>
<tr>
<td><strong>Long Term</strong>*</td>
<td>-35% to -50%</td>
<td>-10% to -20%</td>
<td></td>
</tr>
<tr>
<td><strong>Coder</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Coding Manager</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Change in Charts coded per day</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient</td>
<td>-5 charts/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient</td>
<td>-8 charts/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ED</td>
<td>-24 charts/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Increase in DNFB/DNFC</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase in claims adjustments, rejections / denials &amp; inquiries</td>
<td>Source: The Advisory Board Company Research &amp; Analysis combined with recent Precyse customer data</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Canadian data suggests that productivity loss is never recovered.
**The Impact of the ICD-10 Transition is Far Reaching . . .**

**Diagnostic and procedure codes are utilized from the start of healthcare services through the patient experience from data creation to data use. Each of the populations who contribute to the complete healthcare package are touched to in varying degrees by diagnostic and procedural codes.**

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Hospitals</th>
<th>Health Plans &amp; HMO’s</th>
<th>Federal Government Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic Health Records</td>
<td>HIM / Utilization Review</td>
<td>Claims</td>
<td>Medicare</td>
</tr>
<tr>
<td>Practice Management Systems</td>
<td>Patient Access (Inpatient Ambulatory and Clinics)</td>
<td>Fraud and Abuse</td>
<td>Medicaid</td>
</tr>
<tr>
<td>Billing</td>
<td>Managed Care</td>
<td>Customer Service</td>
<td>- Plus Health Plans functions minus Network and Rating</td>
</tr>
<tr>
<td>Accounts Receivable</td>
<td>Billing &amp; Collections</td>
<td>Reimbursement</td>
<td></td>
</tr>
<tr>
<td>Productivity Loss</td>
<td>Ancillary services (Lab, Rad)</td>
<td>EOBs/ EOCs</td>
<td>- Data Warehousing for statistical reporting</td>
</tr>
<tr>
<td></td>
<td>Pharmacy</td>
<td>Network Contract</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursing</td>
<td>Actuarial</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IT</td>
<td>Rating</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician Order Entry</td>
<td>Underwriting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supply Chain Mgmt</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Specialty Providers**

- Veteran’s & Federal Hospitals
- Nursing Homes
- Urgent Care Providers
- Hospice
- Home Health & DME Providers
- Mental Health Providers
- Substance Abuse Providers
- Physical Therapy Providers
- Drug Manufacturers
- Supply Chain Companies

**Supplemental Health Industry Organizations**

- Third Party Administrators
- Workers Comp
- Auto Liability
- Self Admin Employers
- Clearinghouses
- Programs that address health needs of the poor and uninsured

**Major State Government Programs**

- University Medical Centers
- Children’s Health Programs
- Student Health Programs
- Department of Corrections
- County and Rural Health Programs
- State Public Health Agencies
- State Funded Medical Schools
- State Employee Health Programs

**Health Care Tools & Decision Support**

- Predictive Modeling
- Health Coaching
- Personal Financial Tools, e.g. FSA, MSA
- Federal, State and local authority collection of diagnosis data from Clinical provider for epidemic and new disease analysis
The impact reaches most portions of provider’s business as well as payors and other health care entities.

- **High Impact**
- **Medium Impact**
- **Low Impact**

### Pricing / Contract Management
- Pricing
- Contract / Reimbursement Modeling
- Contract / Payment Analysis

### Patient Access
- Scheduling / Medical Necessity
- Pre-Service / Registration
- Financial Counseling

### Clinical Documentation Integrity
- Charge Capture / Reconciliation
- Coding / DRG Assignment
- Physician / Nursing Documentation
- Clinical Data / Quality Reporting

### Patient Financial Services
- Claim Edits / Claims Processing
- Remittance / Denial Posting
- Account Resolution

<table>
<thead>
<tr>
<th></th>
<th>PEOPLE / TRAINING</th>
<th>PROCESS</th>
<th>SYSTEMS / TECHNOLOGY</th>
<th>REGULATORY COMPLIANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pricing / Contract Management</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Patient Access</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Clinical Documentation Integrity</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Patient Financial Services</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td><strong>PEOPLE</strong></td>
<td><strong>PROCESS</strong></td>
<td><strong>TECHNOLOGY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-------------</td>
<td>----------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| - Increased anatomy and surgical procedure knowledge by coding staff  
- Detailed physician documentation of surgical procedures  
- Extensive retraining requirements for coding and revenue cycle staff  
- May need to hire more coders to support the transition short term to minimize Discharged Not Final Billed increases  
- Productivity loss to be expected during the initial 3 - 6 months due to steep learning curve of coding using ICD-10 | - Reduction in coding productivity  
- Reexamination of payor contracts to address new and obsolete codes  
- Payor analysis and trending will experience a 3 - 5 year impact, due to degradation of existing usage data  
- Increased billing inquiries  
- Increased coding queries to physicians for further data with resultant increase in DNFB  
- Alteration in healthcare data analysis and trending will require extensive remapping efforts (i.e., comparing healthcare outcomes form ICD-9 to ICD-10)  
- Medical management and business rules dealing with codes must be analyzed, redesigned, and tested  
- Increased complexity/requirements for Medical Necessity claim edits | - Code field type/size increase to 3 - 7 alphanumeric characters in all applications using ICD codes (All clinical and financial applications where codes are entered/reported)  
- Redesign system interfaces  
- Recalculation of DRG groupers and case mix indexes  
- Coder editing programs (Example: Encoder) will need to be analyzed, redesigned and tested.  
- Current reports to federal, state, and other regulatory agencies/authorities will need to be analyzed, redesigned and tested. |
By now, most organizations are moving into the last phases of work to be ready for the October 1, 2014 go-live.

High Level ICD-10 Workplan Timeline

<table>
<thead>
<tr>
<th>Due Diligence</th>
<th>Plan</th>
<th>Analyze &amp; Design</th>
<th>Build &amp; Test</th>
<th>Deploy &amp; Operate</th>
</tr>
</thead>
</table>

ICD-10 Program Management (PMO)

**Implementation Milestones:**

- System Upgrades for each system impacted:
  - Includes configuration and build for I-10 edits, rules, etc.
  - Report development and modification
- Interface modifications
- Testing
  - Unit, System and Integrated testing
  - Integrated testing must incorporate all workflows, systems and interfaces
  - External testing with vendors, agencies and payors
- Training
  - Physician documentation training
  - HIM and Coding training
  - Workflow and system changes
  - Other key user training
To achieve a successful outcome, an organization needs to consider the following critical success factors . . .

1. **Physician Readiness**
   - Complete and accurate physician documentation to support ICD-9 and ICD-10 codified data.
   - Adoption of Clinical Documentation Improvement (CDI) program to help with physician engagement.

2. **Achieve Revenue Neutrality through Operational Preparation**
   - Coder retention and recruitment.
   - Adoption of “Dual Coding” period.
   - Knowledge transfer/education provided to key leadership/teams staged according to fully integrated program plan development and execution.
   - Payor – Provider Collaboration: Detailed contracts with other providers, payors and vendors with clear identification of timing, integration and conversion/translation applications.
   - Active participation, training and process updating by all non-HIM entities (Revenue Cycle, Ancillary Departments, etc.) who may be impacted by ICD-10.
   - Robust performance scorecards to actively track progress and solicit process improvements.

3. **IT System(s) Readiness**
   - Fully integrated IT and other systems currently containing ICD-9 codes across all hospital, vendor, payor and other integrated systems (electronic and other).
   - Comprehensive modeling and integrated functional testing plan across the continuum of care.
CASE STUDY: BUSINESS PROCESS HEAT MAP STATISTICS

ONE CLIENT ASSESSMENT INDICATED A NUMBER OF KEY PROCESSES THAT MAY BE IMPACTED AND MUST BE CONSIDERED IN PROCESS REDESIGN & SYSTEM TESTING / REMEDIATION

• Assessment included:
  – 6 Business Process areas
  – Totaling 107 processes

• Process impacts:
  – 37 High
  – 27 Medium
  – 30 Low
  – 13 No
CASE STUDY: ICD-10 INITIAL APPLICATION INVENTORY

This is an initial application inventory of impacted systems; each system impacted will be individually represented in the workplan.
KEY IMPACTS TO PATIENT ACCESS INCLUDE . . .

• Increased time for admitting diagnosis verification
• Interpretation of codes during diagnosis validation of physician orders in ICD-10
• CPOE must be ICD-10-compliant and compliant with meaningful use
• Medical necessity verification with Medically Unlikely Edits (MUE) and National Correct Coding Initiative (NCCI) edits
• Increased time to conduct insurance verification, treatment authorizations and referrals
• Increased time to perform order entry
• Integrated registration and scheduling systems will require audit for correct ICD-10 code entry

NOTE: Diagnostic and procedure codes for services scheduled and/or received on the ICD-10 Compliance Deadline Date must be in ICD-10 format.
KEY ITEMS FOR PATIENT ACCESS TO KNOW AND TO UNDERSTAND IN ORDER TO SUPPORT ICD-10

• Differences and similarities between ICD-9 and ICD-10
  – An understanding of both ensures accurate data entry at the time of scheduling and registration, resulting in a clean claim and less rework

• The meaning of ICD-10-CM and ICD-10-PCS codes, as they have important differences in length and in value of each character
  – General makeup of an ICD-10 code for accurate data entry (i.e. where the decimal point is located, the importance of the “x” placeholder, etc.) and an understanding of the “one to many” concept as the codes are increasing dramatically in volume

• Changes in specificity and their impact on severity of illness and length of stay criteria

• Changes required for treatment authorization and referrals and payor disputed claims

• Understanding of the impact to the revenue cycle continuum
As a Patient Access Leader what should you do?

• Participate as a member of ICD-10 Steering Committee (as appropriate)
• Complete information systems assessment inventory
• Identify staffing, training and budgeting issues for department
• Identify areas requiring operational and policy / procedure changes
• Update current reference documents that staff may use to cross-reference a diagnosis description on an order, etc.
• Review current contractual agreements and ensure compliance
• Attend ICD-10 awareness training sessions and ensure staff attend
• Analyze impact of ICD-10 on operations and payment
• Work along side HIM and Clinical Document Improvement (CDI) leaders to ensure physician engagement and compliance
• Compare metrics to pre-live benchmarks to post-live metrics, identify problem areas and root causes and implement process improvements
KEY IMPACTS TO PATIENT FINANCIAL SERVICES (BILLING & COLLECTIONS) INCLUDE . . .

- All processes and supporting systems associated with electronic exchange of information with payors will need to accommodate ICD-10-CM/PCS codes
- Clinical and quality reporting with payors will need to be updated to include ICD-10-CM/PCS codes
- Contracting and reimbursement mechanisms will need to be reviewed and/or bolstered
- Verify that payor and business associates are both 5010 and ICD-10-CM/PCS compliant
KEY ITEMS FOR PATIENT FINANCIAL SERVICES TO KNOW AND TO UNDERSTAND IN ORDER TO SUPPORT ICD-10

- Differences in the ICD-10-CM/PCS code sets from ICD-9-CM
- Impact of ICD-10 on grouping and payment systems
- Changes required for claims submission, electronic remittance advice or payment explanation, treatment authorization and referrals and payor disputed claims
- Operation of the new ICD-10-CM/CS code edits
- Purpose and use of the General Equivalence Mappings (GEMS) and reimbursement maps
KEY IMPACTS TO PHYSICIANS INCLUDE . . .

• Meaningful Use requirements for the CPOE in relation to diagnoses granularity and specificity of the disease process

• Need to make documentation improvements to meet hospital and medical necessity requirements

• CDI tracking tools will use ICD-10 codes and descriptions, therefore training is critical
Here are some key points to remember:

- Recognize that the ICD-10 conversion touches almost every aspect of the organization and can be a transformative process.
- ICD-10 transition is a reality and requires “all covered entities” to accept and transmit ICD-10 diagnosis and procedure codes.
- The Centers for Medicare & Medicaid Services (CMS) deadline for ICD-10 compliance is October 1, 2014 has been delayed; A new deadline will be announced.
- Providers need to take a holistic approach to ICD-10 which enables their teams to systematically target and address key business processes and functional areas impacted by the ICD-10 conversion.
- Management of risks represents a critical element during the transition.
- Payor / Provider, Physician and Vendor coordination is essential to ensure a seamless transition (e.g., remediation plans and timelines, etc.)