ICD-10 Transition

How can we use the additional year wisely?
ICD-10 Transition:

Where do ‘We’ stand with one additional year to go?

On April 1, 2014, the implementation date for ICD-10-CM/PCS was delayed to a date on or after October 1, 2015.¹ On May 1, 2014 the Centers for Medicare and Medicaid Services announced that the U.S. Department of Health and Human Services will be releasing a new compliance date requiring the use of ICD-10 beginning October 1, 2015. The Rule will also require HIPAA-covered entities to continue using ICD-9-CM through September 30, 2015.²

While October 1, 2014 is no longer a factor, October 1, 2015 and ICD-10 still looms on the horizon. On that date, programs must replace ICD-9 with the ICD-10-CM (Clinical Modification) codeset for submitting diagnoses claims and the ICD-10-PCS (Procedure Coding System) codes for inpatient claims. With just over one year to go, where are we and how do we get to the finish line? What are some of the hurdles in our way? And how can we make best use of this additional time? It depends who “we” are. The overarching questions involve how to maintain business continuity in all different types of entities. The adoption of ICD-10 as a business system-wide changeover can be compared to two major life-changing events: retirement and birth in the healthcare life cycle. Yes, it is the retirement of an old, comfortable friend called ICD-9. Why retirement? It will be phased out by most business processes but still used by groups such as Workers Compensation and other entities for a period of time. ICD-9 is one aspect of the business of healthcare that we have taken for granted for more than 30 years. It changed and grew, but was always there when we needed it. Now we have a new baby to bear and raise. This new process is like a couple readying themselves for a new addition to their household: there is surprise and/or denial, acceptance, education and assessment of financial impact. Then there will be adjustments and lifestyle changes to integrate into the family. And as with most change, acceptance, education and preparation are essential to success. This is not the time to pause, stop and lose momentum. This time can be used well to continue readiness and preparation.

Who will be affected by the ICD-10 changeover?

Several “we” groups are affected by the changeover to ICD-10. Let’s look at a simplified business process of the healthcare billing and payment cycle.

The main groups include the Institutions, Facilities, Locations, Medical/Clinical Providers, Payers and the Support processes for those groups. We always want to say that the healthcare system revolves around the patient, but that is not always true in practice. The average patient does not care about process details; they just want medical care and payment processes to be as seamless as possible.

**Planning for 2015**

We should be revising our schedules to use the time wisely.

On April 23, 2014, Denise Buenning (then with CMS) told an audience at the American Health Information Management Association (AHIMA) ICD-10 Summit that CMS was ready for ICD-10 and that the delay provides another year for testing, allowing for more robust testing with providers.

There is a theory that dual or concurrent coding and processing of ICD-9 and ICD-10 may become a reality. The potential cash flow issues expected with the changeover will be serious enough without adding additional financial issues.

The safest approach is to plan for no additional extension. There have already been two extensions and, with this recent extension, disappointment was expressed by those ready.

**What are some possible business continuity strategies?**

**Hard cutover on legislated date of service.**

This possibility complies with the current CMS official position and is the goal. From a practical perspective, it is improbable that all providers and trading partners will be ready for processing on exactly the same day. However, with the additional year, it should be expected that more will be ready. For those not ready, there could be a significant risk of financial and business continuity disruption. Claims not submitted in the proper format would either be denied or require manual processing. Payment delays may harm providers and hinder access to care. Significant resources will be expended in mitigation activities.

**Dual processing allowing both ICD-9 and ICD-10 for a period of time.**

Dual processing allows a longer migration timeline with significantly less disruption to payments. This would be similar to HIPAA 4010/5010 overlap. Providers who are not quite ready can still have their claims processed. However, with the additional time, it is anticipated that more providers will be ready. Providers who are ready can take advantage of increased code specificity. MCO data could be processed in a mixed format for a period of time. There is a very small risk of duplicate claim payments since most dupe logic is based on HCPCS or NDC – which aren’t changing. Reporting and longitudinal studies are less clear with mixed data.

**Automated translation of ICD-9 to ICD-10 values when claim is received.**

If a claim or service authorization is received with an ICD-9 code after the transition date, it would be automatically converted to ICD-10 based on an approved translation map prior to processing. Outbound transactions for affected providers would require reverse mapping. This enables a cleaner date-of-service transition without requiring all providers to be ready on a specific date. One risk with this process is that the translated code may not match the service performed or medical condition with as much specificity as needed. Legal complications can arise when a provider’s codes are modified without direct permission. More resources could be expended to resolve one-to-many translations which cannot be resolved automatically. Business units that communicate with providers may have to do more research. Potentially greater number of appeals or adjustments will be required. Conversion mapping will need to be refined based on experience.

**Information Technology Readiness**

Information Technology (IT) crosses all aspects of the healthcare payment process. Whether we are talking about electronic medical records or systems directly related to the payment, changes in IT components are well underway. Smart businesses will keep right on planning for the change – even with a new deadline – so that they can hit the ground

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running. The effective deadline to be able to receive claims testing must be completed prior to provider testing. Across the industry, the past year’s efforts need to continue and the time used to continue training and education in order to be ready for the switch to ICD-10. Additional opportunities to practice and gain familiarity with the new codes and processes will result in a more knowledgeable and prepared industry.

Many providers are unaware that they even need to consider claims testing. Others are worried that they are not large enough to matter to the large plans and payers, who in turn are looking at testing requirements, test providers and the costs associated with the testing process. Meanwhile, a third group is so busy or disconnected from the process that they have not even begun to actively consider ICD-10. These groups now have an opportunity to use this time to actively pursue readiness for the change, to learn and to test.

In general, the provider side of the business is concerned about many other details and issues. They prefer to leave the claims testing to the vendors. The ICD-10 education process for the provider, who will create the “input”, has been difficult to ramp up with the official delays and attitudes toward change. To have an effective implementation, we must remember the adage “garbage in, garbage out”. Let’s look at this from the input, the provider’s and the coder’s vantage point.

Who is the initial input side of the process? In general, it is either providers or institutions acting on behalf of the provider. No test, procedure or any type of treatment can be performed without direct intervention of a provider or the provider’s surrogate – a provider’s order is required. Even pre-standing protocol orders are performed under a provider’s guidance. It does not matter if the provider is a facility employee or private practice provider. A provider must document not only the request for an order but in some cases must document a reason that the procedure or test is being requested. The additional time can be used for the provider and coder to work together and collaborate so each has a better understanding of the provider’s daily use of these new codes. This results in cleaner and clearer ICD-10 coding with fewer errors on October 1, 2015.

Testing Initiatives

Use this time for testing. Volunteer for testing wherever and whenever eligible, schedule testing, internally test, and facilitate provider-coder communication. You can sign up for CMS ICD-10 email updates and other information by visiting www.cms.gov/Medicare/Coding/ICD10/Latest_News.html.

Several industry groups have been working toward the goal of testing before implementation needs to occur. These groups include but are not limited to the following:

The Workgroup for Electronic Data Interchange (WEDI) ICD-10 Testing subworkgroup identifies methodologies and best practices for internal and end-to-end testing of ICD-10 implementation changes. Through discussions and individual presentations, the workgroup hopes to develop recommendations for the industry on workable testing methods. The workgroup’s goal is to become a key source for ideas, education and information for stakeholders and develop work products and programs to assist in testing ICD-10-CM and ICD-10-PCS medical codeset implementations. You can learn more at www.wedi.org/workgroups/icd-10/icd-10-testing.

Health Information and Management Systems (HIMSS) has been proactive in the testing realm. They have been leading an ICD-10 Pilot Program that has been gathering cases for standardized testing. HIMSS also works closely with WEDI to be a joint force in the overall ICD-10 migration process. You can learn more at www.himss.org.

The American Health Information Management Association (AHIMA) (www.ahima.org/topics/icd10) and the American Academy of Professionals Coders (AAPC) (www.aapc.com) are both working hard to ready their members for the migration to ICD-10.
Where are you and what to do next?

If you want to drive to Chicago, what road do you take? That depends on your starting point. The same is true with ICD-10. You must first know where you and your staff are in order to set upon your journey. We all know that – but how do we assess it?

“Bear down and plan well,” says John Dingle, a senior health systems engineering analyst at the Mayo Clinic. “If you haven’t already started planning, you need to clearly understand the regulations and what you are being asked to do.”

Readiness assessments are the initial way to see where we are, and therefore where we need to start. There is no one readiness assessment tool, but the four organizations mentioned above would be a good place to start. Each has articles and other tools available to help, whether you are just starting or want to be sure your established plan is still on track. So make a plan now and follow it while making adjustments along the way; it’s much easier to accomplish ICD-10 in small bites.

Education

Overcoming Familiarity and Inertia

What input begins the billing process? Documentation and the proof of that documentation drive what is coded and therefore what is billed. A coder will tell you that there are often processes that are performed but not billed. A biller will tell you they are not concerned with what is performed and look at only what is documented and payable under the contract(s). One of the main ideas that a provider must remember is “if it is not documented, it is not done.”

Many ICD-9 coders are accustomed to certain procedures or providers. They have been able to code a lightly documented treatment or diagnosis because it was a standard function. ICD-9 codes were specific in denoting a disease process; but the level of specificity that ICD-10 requires is far greater.

Think of ICD-9 coding as a ten-story building that has the penthouse built out while the remaining floors are open warehouse. In order to code for ICD-10, all ten floors need to be built out and furnished.

A new standard is required for ICD-10. A coder cannot extrapolate, assume or otherwise infer what a provider may have meant to say or may have done – period. They need to query that provider for more information when needed. This request for more information may be required far more often than it was in the past. An office or department coder could query the physician verbally, but must then note in the chart how, when and what was said. More often the query will be an email to the provider, who will have to access the medical record. The coder will then have to re-code the record. Remember that the coder must walk a fine line between assumptions and bothering the physician.

Preparation

What provider business processes will be most affected by ICD-10?

A variety of business processes will be affected by the ICD-10 implementation. It will only take time and money; but the ramifications could be even more costly if we do not make the right preparations.

Physician Education in the Documentation Process

There is the cost of the training, both in productivity and courses. There is also the cost of the provider’s time to complete more detailed documentation.

“Deborah Grider, President of the National Advisory Board of the American Association of Professional Coders, has estimated that ICD-10 CM will increase documentation activities about 15 percent to 20 percent. This means that overall, we can expect about a 3 percent to 4 percent increase in physician time spent on documentation for ICD-10 CM. Note that this is a permanent increase, not just an implementation or learning curve increase. It is a physician workload increase with no expected increase in payment, due to the increase requirements for providing specific information for coding.”


If the physician documents in the exam room, the patient will have more time with the physician but the physician may see fewer patients. And there is the physician’s time to answer coding queries and to amend documentation if required.

**Coder Education in the Documentation Process**

There is the cost of the training, both in productivity and courses, for coding and billing-related employees. It is difficult to estimate the amount that needs to be spent on this training. Some suggest sending one coder to outside training and then have working sessions at the office for the others. This only works in some groups with the right social and leadership mix.

Education is a “must do”. The additional time can be used for more training, resulting in greater familiarity and fewer difficulties after the switch. When broken down to reasonable groups of information, ICD-10 is not as difficult as some people think. This can continue to be communicated and the knowledge and momentum not lost.

There also is the undefined cost of attrition. Some experienced coders – many with a great wealth of ICD-9 knowledge – are expected to retire rather than face the education process of ICD-10. Unfortunately, a great deal of expert knowledge will retire with them. Hospitals and providers would be wise to incent their experienced staff to stay on and use the time to enhance the education process for both experienced and newer staff.

**Financial Readiness for Possible Cash Flow Delays or Interruptions**

The time spent in the months prior to implementation should also be used to prepare financially for possible cash flow issues that may arise. Some organizations recommend setting aside three months to six months of operating capital or arranging a line of credit to cover potential gaps in accounts receivables. Current field knowledge believes that the value of ICD-9 and ICD-10 claims is very similar. The concern is the timing to get a claim to the payer and the staff to do so may be a large hiccup in the system. For more information, you can review the suggested articles at [www.cms.gov/Medicare/Coding/ICD10/Payer_Resources.html](http://www.cms.gov/Medicare/Coding/ICD10/Payer_Resources.html).

**What has to change and what will be the effect?**

Some physicians are saying, “I know I have to document better, but isn’t that why I use an EMR? I know my medicine – I have trained for years.” Most physicians are very capable from a medical point of view, but were not trained to code in medical school.

The physician knows that certain underlying medical issues are usually present for a main issue to be present. For example, a patient would not be diagnosed with diabetic neuropathy without having diabetes; yet a patient without diabetes can have neuropathy caused by something else. Both must be documented properly. ICD-10 will provide a way to put all of the health issues and underlying causes into a documentable and analytical system. The codes can then be used by researchers and payers to make future health determinations.

The business concerns about the switchover to ICD-10 are multifold:

- **The time needed to document a patient visit in enough detail to be coded in ICD-10 can increase the time the physician needs to document.** This may be done in the exam room with the patient present or at another time.

- **This will reduce the coder’s productivity.** Current practice studies with experienced professional coders have shown that the time required to complete a range of records in ICD-10 vs. ICD-9 has been as much as a 50 percent increase. This means that an increase in the time of trained coding personnel will be required to maintain the same timeframe from visit to billing. This will improve over time, but even with the addition of Computer Aided Coding (CAC) may not return to ICD-9 standards.

- **Your cash flow must be ready for system hiccups.** CMS and many coding organizations recommend preparing for three months to six months of transition expenses. Costs are difficult to estimate due to the variety of size and types of practices and institutions.
• Future processes will be adjusted over time when the results of the ICD-10 change are better understood. Over time, the detail of treatment and overall health outcomes extrapolated from the specificity of the ICD-10 data will change both medical and billing protocols.

Will the providers be ready?
That is the question of the day and many days to follow. Whether a provider is with an institution or a private practice, they have had a great deal of change in the past few years. Just think about some non-medical changes: 5010, Medical EMRs, Meaningful Use and, of course, the overall conversations about the Affordable Care Act. They may be tired of change and not sure how their staff is going to do the next task. Most know this thing called ICD-10 is coming, but are leaving it to the office manager or Health Information Management group to handle it.
First of all, providers and their staffs must accept that the change is real and that ICD-10 is going to be here. The second step is to set a plan. The following are suggestions accumulated from several sources. There are two unwavering items: Now and Implementation. The exact process outlined below should be adjusted by the planner. Remember: luck is really skill applied in a timely manner.

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<td>Plan for Physician Document Enhancement Education now: The physician must understand the documentation changes and is the lead in this process.</td>
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<td>Plan for the Additional Time: Look for opportunities to test, expand and lengthen training, include practicing, improve coding quality and clinical documentation.</td>
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<td>Continue Training for Coders – Anatomy and Physiology: Many coders will turn from being generalists to specialists due to the complicity of the new requirements. Move from general guidelines to specific chapter areas.</td>
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