ICD-10: Ready or Not, Here It Comes

Presented by Cindy Tipton-Cain, MED300O and Laura DeBusk, White Plume Technologies
About MED3000

Core Business
• Group management
• Accountable care organization development
• Revenue cycle management (physician, pathology, EMS)
• Technology management (PM, EHR, ASP solutions, patient portals)
• Education and consulting (coding and compliance, operations, financial)
• Employer services
• Health System / Hospital Alignment

Company Snapshot
• Founded in 1995
• Privately held
• 3,000 employees
• 14 operating centers
• 15,000 providers

Sense of Scale
• 5 million patients
• 22 million patient visits
• 47 million charge records
• 62 million diagnosis records
• 101 million payment records
Learning Objectives

• Increase your overall awareness about ICD-10 and its pervasive impact on your client base
• Highlight the potential financial and regulatory impacts
• Explore how to prepare your clients for the change that ICD-10 will enable
• Discuss Risk Mitigation opportunities for your clients as you prepare for the migration to ICD-10
• Identify financial implications of ICD-10 on small and large systems as well as individual and small providers
• Examine the ICD-10 impact on cash reserves and how to protect and manage reserves
• Review the status of the healthcare industry in terms of financial readiness and industry options for providers for funding ICD-10
What is ICD-10?
What is ICD-10

• *Not* a revised version of ICD-9

• ICD-10 represents a complete change from one coding system to a new one structured in an entirely new way

• Like all medical coding systems, it provides a way to condense textual clinical information into “codes” that can be used for billing and other data-based applications
ICD-10 Benefits

• More accurate payments for new procedures
• Fewer rejected claims
• Fewer improper claims
• Better understanding of new procedures
• Improved disease management
• Better understanding of health outcomes
• Standardization of disease monitoring and reporting internationally
ICD-10 Is Really Two Different Code Sets

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>ICD-10-PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• International Classification of Diseases, 10th Revision, Clinical Modification</td>
<td>• International Classification of Diseases, 10th Revision, Procedure Coding System</td>
</tr>
</tbody>
</table>

There is no relationship between the two code sets – they have completely different structures and uses.
**What’s ICD-10-CM?**

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnosis Coding System – Used to report the patient’s condition (i.e., what’s wrong with the patient)</td>
</tr>
<tr>
<td>• Direct replacement for ICD-9-CM Volumes 1 &amp; 2</td>
</tr>
<tr>
<td>• Will be used in all settings – hospital inpatient, hospital outpatient, physician office, etc.</td>
</tr>
<tr>
<td>• Like ICD-9-CM, developed and maintained by the World Health Organization and the National Center for Health Statistics within the Centers for Disease Control</td>
</tr>
</tbody>
</table>
The ICD-10-CM

“Official Guidelines”

• As with ICD-9-CM, ICD–10–CM is supplemented by a set of “Official Guidelines” that are designated as part of the ICD-10-CM code set by the HIPPA “medical data code set” regulations (45 CFR § 162.1002(C)(2))

• The Official Guidelines provide detailed guidance on the use of the ICD-10-CM code set

• The 2012 ICD-10-CM Official Guidelines are available from http://www.cdc.gov/nchs/icd/icd10cm.htm#10update
ICD-10-CM Example

J09 Influenza due to certain identified influenza viruses

Excludes 1: Influenza due to other identified influenza virus (J10.-)
  Influenza due to unidentified influenza virus (J11.-)

J09.0 Influenza due to identified avian influenza virus
  Avian influenza
  Bird flu
  Influenza A/H5N1

J09.01 Influenza due to identified avian influenza virus with pneumonia
  Code also associated lung abscess, if applicable (J85.1)

J09.010 Influenza due to identified avian influenza virus with identified avian influenza pneumonia

J09.018 Influenza due to identified avian influenza virus with other specified type of pneumonia
  Code also the specified type of pneumonia

J09.019 Influenza due to identified avian influenza virus with unspecified type of pneumonia

J09.02 Influenza due to identified avian influenza virus with other respiratory manifestations
**What’s ICD-10-PCS?**

<table>
<thead>
<tr>
<th>ICD-10-PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Procedure Coding System – Used to report surgical procedures performed</td>
</tr>
<tr>
<td>• Direct replacement for ICD-9-CM Volume 3</td>
</tr>
<tr>
<td>• Only used in a hospital inpatient setting (and only for reporting facility services)</td>
</tr>
<tr>
<td>• Like ICD-9-CM Volume 3, ICD-10-PCS was developed and is maintained by CMS</td>
</tr>
</tbody>
</table>
The ICD-10-PCS

“Official Guidelines”

• CMS has released a set of “Official Guidelines” for ICD-10-PCS

• Like the ICD-10-CM Official Guidelines, the ICD-10-PCS Official Guidelines are designated as part of the ICD-10-PCS code set by the HIPPA “medical data code set” regulations (45 CFR § 162.1002(C)(3))

• The 2012 ICD-10-PCS Official Guidelines are available from https://www.cms.gov/ICD10/11b15_2012_ICD10PCS.asp#TopOf Page
How Big Could It Be?

ICD-9-CM

- Diagnosis: 14,025
- Procedures: 3,824

- 820.02, Fracture of midcervical section of femur, closed

ICD-10-CM & ICD-10-PCS

- Diagnosis: 68,069
- Procedures: 72,589

- S72031A, Displaced midcervical fracture of right femur, initial encounter for closed fracture
- S72031G: Displaced midcervical fracture of right femur, subsequent encounter for closed fracture with delayed healing
- S72032A: Displaced midcervical fracture of left femur, initial encounter for closed fracture
- S72032G: Displaced midcervical fracture of left femur; subsequent encounter for closed fracture with delayed healing
What is ICD-10?

ICD-10-CM is the United States' clinical modification of the World Health Organization's ICD-10 system.

The system has been expanded to include more health-related conditions and greater specificity.

Per the Department of Health and Human Services, the compliance date for implementation of ICD-10-CM and ICD-10-PCS is **October 1, 2013. Delayed**

“STAY THE COURSE” regarding implementation preparation, per the American Health Information Management Association (AHIMA) and the Centers for Medicare & Medicaid Services (CMS)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>• Payers and providers should begin internal testing of Version 5010 standards for electronic claims</td>
<td>• Internal testing of Version 5010 must be complete to achieve Level I Version 5010 compliance</td>
<td>• Payers and providers should begin external testing of Version 5010 for electronic claims</td>
<td>• External testing of Version 5010 for electronic claims must be complete to achieve Level II Version 5010 compliance</td>
<td>• All electronic claims must use Version 5010</td>
<td>• Claims for services provided on or after this date must use ICD-10 codes for medical diagnosis and inpatient procedures</td>
</tr>
<tr>
<td></td>
<td>• Providers should form ICD-10 task force</td>
<td>• CMS begins accepting Version 5010 claims</td>
<td>• Version 4010 claims are no longer accepted</td>
<td></td>
<td>• CPT codes will continue to be used for outpatient services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Version 4010 claims continue to be accepted</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ICD-10 Code Comparison Examples

- **Tobacco Abuse**
  - ICD-9-CM: 1 Codes
  - ICD-10-CM: 5 Codes

- **Diabetes Mellitus**
  - ICD-9-CM: 10 Code
  - ICD-10-CM: 318 Codes

- **Tobacco Abuse**
  - ICD-9-CM: 1 Codes
  - ICD-10-CM: 5 Codes
ICD-10-PCS Code Comparison Examples

- **Mechanical complication of other vascular device, implant or graft**
  - ICD-9-CM: 1 Code
  - ICD-10-CM: 156 Codes

- **Suture of Artery**
  - ICD-9-CM: 1 Code
  - ICD-10-PCS: 276 Codes

- **Angioplasty**
  - ICD-9-CM: 1 Code
  - ICD-10-PCS: 854 Codes

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The GEMs

- CMS has developed a bidirectional crosswalk, referred to as the General Equivalence Mappings (GEMS), between ICD-9-CM and ICD-10-CM/PCS

- There are GEMs for over 99 percent of all ICD–10–CM codes and for 100 percent of the ICD–10–PCS codes
Practical Mappings

GEM Examples – ICD-9 to ICD-10

**ICD-9-CM:** 902.41 Injury to renal artery

**ICD-10-CM GEM:** S35.403A
Unspecified injury of unspecified renal artery, initial encounter

**ICD-9-CM:** 50.24 Percutaneous ablation of liver lesion or tissue

**ICD-10-PCS GEM:** 0F503ZZ
Destruction of Liver, Percutaneous Approach
Importance of Physician Documentation
It is so important to remember……

Physicians know *how* to practice medicine.

What is needed now is to better understand how to **DOCUMENT** the practice of medicine!
Strategies for ICD-10 Preparation

• “Build and expand” upon present Clinical Documentation Initiatives
  – Focus on communicating severity-of-illness and medical necessity
  – Familiarity with ICD-10 documentation specificity requirements
    • Clinical specificity
  – Time capsule:
    • Tomorrow is Today!
    • Proceed with Explicitness!
ICD-10 Common Theme

• Expansion of Code Sets
  – Specificity in clinical documentation
  – Specificity in clinical classification
  – Specificity in why resources are used in care mgt.
• Change in clinical documentation thought process
  – “Clinical medicine” and “Medical Necessity”
• Completeness and accuracy of clinical documentation
  – Severity of illness
  – Risk of Morbidity and Mortality  Pay For Performance
  – Risk of Admission
What really counts?

• Specificity in Documentation

• Bridging the gap between clinical & ICD-9/10 classification language

• Call & Describe it as you see it

• Capturing the clinical facts and translating them into meaningful documentation that supports the medical necessity and level of care
Sad but true……

Documentation of Urosepsis
Has no code within ICD-10……..

UTI with Sepsis,
Bladder Infection, or other Dx
must be explicitly documented.
7th Character Extension

Code Extensions

• Most categories have 7th character extensions required for each applicable code
• Include A, D, S, Z
• A – Initial encounter
• D – Subsequent encounter
• S – Sequela
• Z – Aftercare
Common Character Extensions

Extension A

- Extension “A”, initial encounter is used while the patient is receiving active treatment for the injury. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician.

Extension D

- Extension “D” subsequent encounter is used for encounters after the patient has received active treatment of the injury and is receiving routine care for the injury during the healing or recovery phase. Examples of subsequent care are: cast change or removal, removal of external or internal fixation device, medication adjustment, other follow up visits following injury treatment.
Common Character Extensions

Extension “S”

- Extension “S”, sequela, is for use for complications or conditions that arise as a direct result of an injury, such as scar formation after a burn. The scars are sequela of the burn. When using extension “S”, it is necessary to document both the injury that precipitated the sequela and document the sequela itself. The “S” extension identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.
Common Clinical Examples

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 278.01- Morbid Obesity (w/o BMI)</td>
<td>• E66.2- Morbid (severe) obesity with alveolar hypoventilation</td>
</tr>
<tr>
<td>– Not a CC</td>
<td>– CC under ICD-10</td>
</tr>
</tbody>
</table>

Document the exact BMI.....Why??

Coders MUST select BMI of:

- 19 or less
- 30-39 BMI
- 20-29 BMI
- 40-49 BMI
Heart Failure

- I50.1 Left ventricular failure
- I50.2 Systolic (congestive) heart failure
- I50.20 Unspecified systolic (congestive) heart failure
- I50.21 Acute systolic (congestive) heart failure
- I50.22 Chronic systolic (congestive) heart failure
- I50.23 Acute on chronic systolic (congestive) heart failure
- I50.30 Diastolic (congestive) heart failure
- I50.30 Unspecified diastolic (congestive) heart failure
- I50.31 Acute diastolic (congestive) heart failure
- 150.32 Chronic diastolic (congestive) heart failure
- I50.33 Acute on chronic diastolic (congestive) heart failure
- I50.40 Combined systolic (congestive) and diastolic (congestive) heart failure
- I50.40 Unspecified combined systolic (congestive) and diastolic (congestive) heart failure
- I50.41 Acute combined systolic and diastolic (congestive) heart failure
- I50.42 Chronic combined systolic and diastolic (congestive) heart failure
- I50.43 Acute-on-chronic combined systolic and diastolic (congestive) heart failure
- I50.9 Heart failure, unspecified
**Example: Combination Diagnosis**

Decubitus Ulcers – appropriate documentation of the exact stage and location must be present.

**Stages of Pressure (Decubitus) Ulcers:**

- **Pressure ulcer, Stage I** - Intact skin with non-blanchable redness of a localized area (usually over a bony prominence)

- **Pressure ulcer, Stage II** - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

- **Pressure ulcer, Stage III** - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

- **Pressure ulcer, Stage IV** - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

- **Pressure ulcer, Unstageable** - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.
Example: Combination Diagnosis

Decubitus Ulcer Sites
(include but not limited to):

- Sacrum
- Elbow
- Knee
- Ankle
- Thigh
- Calf
- Heel
- Midfoot
Other Considerations

- Abnormal findings (lab, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance

  Clinical Significance → Clinical Query
Impact of ICD-10 on DRG Assignment

- CMS did not address the impact of ICD-10 on DRG assignment in the ICD-10 Final Rule
- However, CMS and 3M have used the GEMs to convert the MS-DRG definitions from ICD-9-CM to ICD-10
- CMS and 3M found that the GEMs were 95% to >99% effective in converting the MS-DRGs to ICD-10
ICD-10 Impact Overview
ICD-10 Impact

Physician practices must understand, anticipate, and effectively address the impact of the ICD-10 transition to the clinical and management systems and functions including, but not limited to:

• Coverage determinations
• Payment determinations
• Plan structures
• Medical review policies
• Statistical reporting
• Actuarial projections
• Quality measurements
• Fraud and abuse monitoring
Who is impacted by ICD-10?

Everyone!!

- Front – Scheduling Access Areas
- Middle – Coding, CDI Case Management
- Back – Billing, Reimbursement

- Documentaion Analysis
- ICD-10 Education
- Process Improvement
- Monitoring

- Staffing Effectiveness
- Assessment of Revenue Impact
- Process Improvement
- Decision Support Reporting Impact

- IT Systems
- Capability Communication
- Functionally
- Vendor Preparedness

- Physician Documentation
- Physician Integration
- Physician Performance
If you care for a patient, handle a medical record, and/or process a claim your workflow will be profoundly impacted by the migration to ICD-10.
Financial Review
### 7 Year Cost Analysis ICD – 10

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<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
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<tr>
<td><strong>Training</strong></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Coders – Inpatient</td>
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<td>$0</td>
<td>$32</td>
<td>$159</td>
<td>$21</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Coders – Outpatient</td>
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<td>$0</td>
<td>$12</td>
<td>$96</td>
<td>$12</td>
<td>$50</td>
<td>$0</td>
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<tr>
<td>Code Users</td>
<td>$0</td>
<td>$0</td>
<td>$4</td>
<td>$33</td>
<td>$4</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Physicians</strong></td>
<td>$0</td>
<td>$0</td>
<td>$104</td>
<td>$835</td>
<td>$104</td>
<td>$0</td>
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<tr>
<td><strong>Subtotal</strong></td>
<td>$0</td>
<td>$0</td>
<td>$152</td>
<td>$1,123</td>
<td>$141</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Productivity</strong></td>
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<td></td>
<td></td>
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<tr>
<td><strong>Losses</strong></td>
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<tr>
<td>Coders – Inpatient</td>
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<td>$10</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Coders – Outpatient</td>
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<td>$9</td>
<td>$0</td>
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<tr>
<td>Physician Practices</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$12</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Improper and returned claims</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$329</td>
<td>$165</td>
<td>$49</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$31</td>
<td>$329</td>
<td>$165</td>
<td>$49</td>
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<tr>
<td><strong>System Changes</strong></td>
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<td>Providers</td>
<td>$23</td>
<td>$45</td>
<td>$75</td>
<td>$8</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Software Vendors</td>
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<td>$35</td>
<td>$58</td>
<td>$6</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Payers</td>
<td>$30</td>
<td>$59</td>
<td>$99</td>
<td>$10</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<td>Government</td>
<td>$77</td>
<td>$154</td>
<td>$256</td>
<td>$26</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Subtotal</strong></td>
<td>$147</td>
<td>$293</td>
<td>$640</td>
<td>$1,204</td>
<td>$470</td>
<td>$165</td>
<td>$49</td>
</tr>
</tbody>
</table>

**TOTAL COST (IN MILLIONS)**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
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<tr>
<td>$147</td>
<td>$293</td>
<td>$640</td>
<td>$1,204</td>
<td>$470</td>
<td>$165</td>
<td>$49</td>
</tr>
</tbody>
</table>

*Source: Center for Medicare and Medicaid Services (2010)*
Q| What is your organization’s projected cost to be ICD-10 ready by 2013 (including labor, hardware, software, training, consultants, etc.)?

- More than $20 million: 1%
- $10.1 million-$20 million: 2%
- $5.1 million-$10 million: 1%
- $1.1 million-$5 million: 9%
- $500,000-$1 million: 12%
- Less than $500,000: 20%
- No estimate yet: 38%
- Not Sure: 18%

Expected Denial Reasons

Q | Select the top reason you expect to see a decrease in your revenue.

- Incomplete physician documentation: 47%
- Payers will not be ready in time: 15%
- Coding staff mistakes: 12%
- Shift in DRGs: 11%
- Delays in submission of bills: 7%
- Our technology won’t be ready in time: 4%
- Other: 4%
Summary Financial Impact

Decrease in Cash Flow / Loss of Revenue

- Industry experts from CMS and AHIMA estimate the following:
  - Denial rates will increase by 100% to 200%
  - Accounts receivable days will be extended by 20% to 40%
  - Healthcare organizations will be hindered with payment declines for more than 2 years after the implementation Date of October 1, 2013
  - Claims-error rates will increase from 6% to 10% (The average current rate is close to 3%)

- According to the American Society of Clinical Oncology, Estimated Organizational Cost by Bed Size

<table>
<thead>
<tr>
<th>Bed Size</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>400 +</td>
<td>$1.5 Million - $5 Million</td>
</tr>
<tr>
<td>100 – 400</td>
<td>$500,000 - $1.5 Million</td>
</tr>
<tr>
<td>&lt; 100</td>
<td>$100,000 - $250,000</td>
</tr>
</tbody>
</table>
# Sample ICD-10 Financial Impact Analysis

## Coders Training

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Coders</td>
<td>15</td>
</tr>
<tr>
<td>Anticipated new hires</td>
<td>100%</td>
</tr>
<tr>
<td>Coder Recruiting Costs</td>
<td>$30,000</td>
</tr>
</tbody>
</table>

## Coder Training

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Training Hours 2013 (Existing Coders)</td>
<td>50</td>
</tr>
<tr>
<td>Initial Training Costs per hour</td>
<td>$50</td>
</tr>
<tr>
<td>Annual Training Costs per hour</td>
<td>$25</td>
</tr>
</tbody>
</table>

## Coder Productivity

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Decrease during Transition Period</td>
<td>29%</td>
</tr>
<tr>
<td>Decrease during Permanent Period</td>
<td>15%</td>
</tr>
<tr>
<td>Outsourced Coder Cost per year</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

## Clinical Documentation Training

### Number of Physicians
- 100

### Upfront Group Training Sessions

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Training Sessions</td>
<td>5</td>
</tr>
<tr>
<td>Cost per Hour</td>
<td>$500</td>
</tr>
<tr>
<td>Total Group Training Costs</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

### One-on-One training

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing Training Costs per hour</td>
<td>$200</td>
</tr>
<tr>
<td>Hours of ongoing training per physician</td>
<td>10</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Total Training</td>
<td>$</td>
</tr>
<tr>
<td>IS Staff Augmentation</td>
<td>$ 115,000</td>
</tr>
<tr>
<td>HIM Coding Staff Augmentation</td>
<td>$</td>
</tr>
<tr>
<td>Revenue Cycle Staff Augmentation</td>
<td>$</td>
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<tr>
<td>IS Software Upgrades</td>
<td>$ 75,000</td>
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<tr>
<td>Technology Upgrades</td>
<td>$ 10,000</td>
</tr>
<tr>
<td>New Software</td>
<td>$</td>
</tr>
<tr>
<td>Reports and Forms</td>
<td>$</td>
</tr>
<tr>
<td>Interface and Other Testing</td>
<td>$</td>
</tr>
<tr>
<td>TOTALS:</td>
<td>$ 200,000</td>
</tr>
</tbody>
</table>
Compliance Risk
Current Compliance Environment

Recently created regulatory agencies charged with improving efficiencies within the healthcare delivery system and reducing the incidence of improper payments include:

- Zone Program Integrity Contracts (ZPIC)
- Medicare Drug Integrity Contractor (MEDIC)
- Medicaid Integrity Contractors (MIC)
- Medicaid Recovery Audit Contractor Program
- Medicare Recovery Audit Contractor Program (RAC)
- Health Care Fraud Prevention and Enforcement Team Task Force (HEAT)
- Fraud and abuse provisions of Patient Protection and Affordable Care Act of 2010 (ACA) and related administrative roles
Current Compliance Environment

Recently enacted legislation includes:

- Fraud and Abuse Provisions of ACA; Implications for Providers
- Expanded False Claims Act (FCA); Implications for Providers
- Amended Federal Sentencing Guidelines; Implications for Providers
- HIPAA Privacy Standards
ICD-10 Impact on Compliance Risk

A huge potential for double billing exists if two systems (ICD-9 and ICD-10) remain in use during the transition period:

- This scenario could potentially create unintentional billing compliance risks.
- The shortage of experienced coding professionals also poses a risk since medical coders nearing retirement age may elect to retire rather than learn a new system.

Additionally, the General Equivalency Mappings (GEMS) do not provide a definitive map from ICD-9 to ICD-10 with only 5% mapping accurately 1:1 with ICD-10 codes:

- Because ICD-9 codes could map into multiple ICD-10 codes, this risk rises even more.
- It is important to note that ICD-10 conversions include manual review and monitoring due to the significant differences in language and structure between ICD-9 and ICD-10.
Risk Mitigation
Risk Mitigation Strategies

Key Areas of Compliance Risk

Data Integrity – prepare for delayed accepted batches

IT Preparedness – prepare for payor /vendor delays

Adjust AR Reserves as Needed

HIM Preparedness

Denial Tracking Tool

Right size staff to handle increased volume

Budget for potential cash flow impact
**Thrive in the Transition**

The realization of the opportunities, and the avoidance of the risks associated with the migration to ICD-10 will fundamentally depend on the individuals within your organization. Specifically, their ability to thrive within this changing environment.

To support this, create a holistic approach that:

- Illustrates the impact of the ICD-10 migration across the organization;
- Diagnostically assesses the readiness of individuals to accept and thrive in a changing environment;
- Design a sponsorship model that leverages the nature of the healthcare industry and intuitively distributes responsibility; and
- Developing a blueprint that pulls together all the training effort required across the organization for success.
Risk Mitigation: “The Must Do’s”

1. Create an ICD-10 impact awareness throughout the organization
2. Ensure your foundational IS structure is actively preparing for the transition
3. Define your change approach to ensure you have defined the proper structure and sponsorship
4. Develop projections of operational needs, including staffing and internal educational training
5. Identify specific documentation gaps to determine focused educational needs
6. Calculate potential impact on financial results
Risk Mitigation Strategies

- Review existing software, including interfaces, to ensure its ability to successfully transition to ICD-10

- Train clinical and administrative staff on new code sets, technological changes as well as fraud, waste, and abuse regulations and reporting

- Review Third Party agreements to ensure any vendors involved in billing processes will be compliant with ICD-10 requirements

- Ensure clinical documentation procedures reflect the increased level of detail required by ICD-10

- Contract with outside entities to audit six (6) to twelve (12) months of claims submitted by an organization to identify any activity that might be considered fraudulent

- Take immediate corrective action where necessary
Focused Specifics: Documentation

1. Focus on good documentation, which directly impact accurate billing and payment timing
2. Be aware of new ICD-10 documentation guidelines in order to evaluate provider documentation for appropriateness, thoroughness, and completeness
3. Take great care to document procedures, labs, and diagnostics performed in order to capture the essence of the total care provided during hospital admissions
Focused Specifics: Collaboration

4. Collaboration, transparency, and communication between payers and providers
5. Train and problem solve through the use of task forces
6. Encourage CMS to continue perfecting payment groupers and mappings
7. Collaborate with other healthcare stakeholders to create an industry test bed
How should we prepare for ICD-10 cash flow delays?

Healthcare providers can best prepare for anticipated cash flow delays by beginning to plan now. Some areas to consider include, but may not be limited to:

- Expenses
- Receivables
- Your primary third party payers
Focus on expenses

• Renegotiate terms with major suppliers to create a more balanced payment schedule over time
• Identify and implement other cost saving measures in advance of October 2013
• Aggressively manage inventory levels to avoid expensive overstock costs
• Reduce other administrative overhead where possible
Focus on receivables

- Manage your Accounts Receivable (AR) aging aggressively, minimize charge-offs and denied payments
- If you have not already done so, consult with your banker about adopting best practices, procedures, and products that will enable you to collect patient co-pays or deductibles at the time of patient encounter
- Work all denials and rejections aggressively to eliminate their occurrence and ensure more first time third party payer payments
Establish dialogue and candid discussions with your primary third party payers now

- Learn how each one plans to prepare for ICD-10 changes, ask if they are implementing new rules for claims submission or re-submission
- Share your plans for implementing these changes with them
- Identify shared goals and objectives to ensure a combined approach, minimizing disruption to either’s coding processes (win-win)
How much cash flow should we put away in order to sustain our business?

There is no magic number that will work for every healthcare provider. Each situation is unique. Your specific situation will need to be carefully considered by your senior management in consultation with their trusted financial advisor or banker.
What kind of financial questions should we be asking our financial institutions if we are a large hospital? OR a small provider group in private practice?

Regardless of the type of healthcare provider, the questions are the same:

• Can you help me forecast my working capital?
• What steps can I take now to manage some of this myself?
• What additional products and services can the bank offer to accelerate days in AR and extend suppliers term and days in AP?
• What credit products can help with unexpected negative impacts to working capital during the initial period of transition to ICD-10 codes in late 2013 and early 2014?
What other strategies should we implement to prepare to manage financial risks?

Ensure you have identified all of the changes required in your systems and processes. Many payers and providers are approaching this as merely a code or system change. It is important to give thorough consideration to the following questions:

- How and where in all of your processes and workflows will accurate coding come into play?
- What are the potential organizational impacts of coding errors that could ultimately lead to member or patient dissatisfaction and contribute to higher administrative costs?
- Engage in active and candid discussions with your primary third party payers.
  - Work together with your payers to identify shared goals and objectives in order to minimize the disruption to either coding processes.
  - Determine and understand any changes your payers are implementing in their claims submission or resubmission policies and procedures as a result of ICD-10 code changes.
  - Share your plans for implementing ICD-10 code changes, including your system changes and timing, staff training, and any additional oversight you are going to implement as you make this transition.
What are some examples of successful exit strategies for smaller providers?

You should begin preparing now so your balance sheet and income statement can weather any temporary disruptions that may be caused by the healthcare industry ICD-10 transition. ICD-10 is one of the most significant changes recently required and is happening at the same time as several other healthcare regulatory and market changes – Meaningful Use, Medical Loss Ratios, Affordable Care Act (ACA), Accountable Care Organizations (ACO) – and is impacted by the preceding 5010 format changes for all HIPAA transactions to accommodate the ICD-10 code changes.
A Layman’s view...
 clinicians

Schedulers
• pre-authorizations
• appointment type

RCM
• documentation detail
• interaction with payers

Suppliers
• authorizations
• medical necessity

Coders
• requests for more documentation
• requirements may require contacting patient

Utilization
• clinical performance indicators
• quality measures
• value based purchasing

Payers
• denials, pended claims
• unspecified dx
• audits
• rules, guidelines, edits
## Coding Increase by Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>ICD-9 Codes</th>
<th>ICD-10 Codes</th>
<th>Coding Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>178</td>
<td>430</td>
<td>2.5 x</td>
</tr>
<tr>
<td>Dermatology</td>
<td>172</td>
<td>603</td>
<td>3.5 x</td>
</tr>
<tr>
<td>OB-GYN</td>
<td>220</td>
<td>777</td>
<td>3.5 x</td>
</tr>
<tr>
<td>Family Practice</td>
<td>229</td>
<td>829</td>
<td>3.6 x</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>204</td>
<td>848</td>
<td>4.2 x</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>165</td>
<td>836</td>
<td>5 x</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>143</td>
<td>5,843</td>
<td>40.9</td>
</tr>
</tbody>
</table>

### AAFP Superbill Template for ICD10

#### Family Practice Management Superbill Template

From the American Academy of Family Practice (AAFP) Family Practice Management Toolkit
(https://www.aafp.org/bm/200509004336.htm)

<table>
<thead>
<tr>
<th>Date of service</th>
<th>Service description</th>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Service Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### ICD-10 CPT Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Additional Information

- Medicare preventive services
- Laboratory services
- X-rays
- Facility services
- Drugs
- Immunizations
- Preventive care
- Tobacco cessation

---

**Note:** This template is designed to accommodate various professional services, and includes codes for medical, surgical, and diagnostic procedures. For comprehensive service coverage, consult the AAFP Family Practice Management Toolkit for the most accurate and up-to-date information.
Coding and documentation

Requires new information

Tells a more detailed story

![Diagram showing coding and documentation with ICD-10 scenarios for diagnoses related to knee and hip conditions.]
## Limitations of GEMs

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>GEMs</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>V58.89</td>
<td>Z51.89 Encounter for other specified care</td>
<td>S51.011D Laceration without foreign body of right elbow, subsequent encounter</td>
</tr>
<tr>
<td>Other specified aftercare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E8301</td>
<td>V90.89XA Drowning and submersion due to other accident to unspecified watercraft, initial encounter</td>
<td>E8301 Wilson’s disease (ICD-9 = 275.1)</td>
</tr>
<tr>
<td>Accident to watercraft causing submersion injuring occupant of small boat powered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
What’s on your payor’s plate..

Adjudication…
Continual changes to payment policies / Denials
Backwards mapping from ICD-10 to ICD-9 / Improper payments, carve outs
Managing commercial, WC and auto claims

Operational changes…
System changes and associated issues
Slow downs in every area
Increased demands on help lines and provider relationship managers

Policy changes…
• Pre-authorizations and referrals
• Medical necessity
• Proprietary edits
• Coverage policies and formularies
• Appeals
• Timely filing – especially for claims prior to the cut off

Contracting…
Lack of meaningful historical data for contracting when comparing ICD-9 to ICD-10
Payor readiness for ICD-10

% of Payors surveyed

- 61% Not sure or will not meet deadline
- 30% "Likely" to meet deadline
- 9% Will meet deadline

Source: HealthEdge survey, 2012
## Total number claim edits by type and payer

<table>
<thead>
<tr>
<th>Type</th>
<th>Aetna</th>
<th>Anthem</th>
<th>Cigna</th>
<th>HCSC</th>
<th>Humana</th>
<th>Regence</th>
<th>UHC</th>
<th>Medicare</th>
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</thead>
<tbody>
<tr>
<td>CPT</td>
<td>36,266</td>
<td>36,796</td>
<td>36,509</td>
<td>36,796</td>
<td>36,796</td>
<td>36,815</td>
<td>31,135</td>
<td>36,568</td>
</tr>
<tr>
<td>ASA</td>
<td>1,070</td>
<td>1,070</td>
<td>1,070</td>
<td>1,070</td>
<td>1,070</td>
<td>1,070</td>
<td>1,070</td>
<td>1,070</td>
</tr>
<tr>
<td>CMS</td>
<td>184,220</td>
<td>185,371</td>
<td>185,365</td>
<td>185,371</td>
<td>185,371</td>
<td>185,371</td>
<td>169,178</td>
<td>185,371</td>
</tr>
<tr>
<td>Payerspecific</td>
<td>62,335</td>
<td>76,726</td>
<td>1,190</td>
<td>123</td>
<td>5,033</td>
<td>5,000</td>
<td>82,868</td>
<td>19,683,450</td>
</tr>
</tbody>
</table>

Source - AMA 2012 National Health Insurer Report Card
Closed Loop Denial Prevention

- Denied Claim / New Policy
- Closed Loop Denial Prevention
- Rule fires for all employees every time
- New Rule Built
Documentation Readiness

• Identify the diagnoses/DRGs that represent the top 20% of your revenues OR represents the most frequently used by provider OR represents the highest risk from a documentation perspective.

• Convert to ICD-10 with GEMs

• Review documentation and see if it supports the GEMs coding

• Refine the GEMs coding to appropriate level of accuracy and specificity

• Now compare with existing documentation

• Define your gaps

• Map backwards from ICD-10 to ICD-9 to project adjudication/contract issues with top 5 payers
Create a project management team with an executive sponsor.

Perform an impact assessment to identify impact with systems, staff, policies, and procedures, workflows, cash flows and other projects.

Plan your business and technical implementation strategy.

Estimate and secure budget to include software, hardware, and staff training.

Contact system vendors and service providers to assess their readiness, evaluate contracts, testing protocols.

Contact key health plans to assess their readiness and evaluate any issues with carve outs, special contractual considerations, policy updates or documentation requirements.

Map forms like superbills to ICD-10 and evaluate impact on clinical staff. Replace with electronic solutions as appropriate.

Assess tools for denials management and implement solutions that will weather the spike in new edits and denials.

Train a core group of coders, billers and clinical staff who will be responsible for executing your Implementation Plan for readiness.

Secure line of credit, implement cost-saving tactics wherever possible and reserve cash to prepare for financial shortfalls and cash flow issues.

Reduce your Days in AR to a minimum, knowing that the mandate will add a significant increase to DAR.

**Documentation - must complete in time for training**

- Identify the diagnoses representing the top 20% of your revenues or most frequently used by your providers.
- Map them to ICD-10 using GEMs.
- Select a sample of patients and review their clinical documentation to evaluate whether it supports the GEMs ICD-10 coding.
- Refine the GEMs coding to the appropriate ICD-10 coding for accuracy and specificity.
- Compare the new ICD-10 coding with existing documentation and define your documentation gaps.
- As a final step, map backwards from ICD-10 to ICD-9 to identify any adjudication or contract issues.

**Training - plan to repeat sessions and testing as you get closer to October 2014**

- Educate staff on documentation gaps and new requirements.
- Begin internal testing and coordinate with coding staff, billing and technical resources including your vendors.
- Review testing results and refine documentation, coding and systems.
- Begin training clinical staff, with increasing intensity and testing as the mandate approaches.
- Benchmark your key performance indicators to compare with the new normals post mandate.
Key Resources

- ICD-10 Proposed and Final Rules

- CMS Website on ICD-10
  - [https://www.cms.gov/ICD10/](https://www.cms.gov/ICD10/)

- CDC Website on Classification of Diseases
  - [http://www.cdc.gov/nchs/icd.htm](http://www.cdc.gov/nchs/icd.htm)

- CMS ICD-10-CM Quick Reference Guide
Questions?