Ensuring a successful ICD-10 conversion

Industry experts recommend steps to smooth the transition.

By Phil Colpas, September 2013

Admittedly, the United States is not often painted in a favorable light where healthcare is concerned. In general, healthcare lags behind its business counterparts in many areas of technology; the U.S. is ranked 37th globally in healthcare, according to the New England Journal of Medicine; and though we continue to struggle with ICD-10 conversion, many other countries made the switch decades ago. Full compliance to ICD-10 remains federally mandated in the U.S. for Oct. 1, 2014, delayed a year from its initial deadline. Meanwhile, the first version of ICD-11 is slated to debut in 2015.

Can we really call ourselves healthcare IT adoption leaders when we’re still struggling with implementing ICD-10, a system that many other countries have been using for at least 10 years?

The American Medical Association estimates the administrative transition costs for physicians will be $87,000 to $2.7 million per practice – far higher than initially thought – plus potential losses in reimbursement due to incorrect coding.

We’ve all heard the ICD-10 backlash: Deadlines are too tight; conversion will disrupt workflow and revenue; training coders is too costly and labor intensive.

Here now, commentary from our select panel of experts on the steps to take to help ensure a smoother transition to ICD-10.

Summer Humphreys, executive consultant, Beacon Partners

Five lessons learned for a successful conversion strategy

Is your organization properly positioned to meet the ICD-10 conversion deadline? It’s clear that there won’t be any more delays. ICD-10 will be critical to the success of all healthcare organizations following the deadline. Here are five steps to take to plan for a successful, on-time conversion.

1. **GAP analysis to guide your organization.** A GAP analysis starts with understanding how the ICD-10 coding touches each area within your organization and will allow you to develop a road map of what areas need to be tackled.
2. **Governance key to integration.** Because there are so many working parts and the deadline is fast approaching, a key component to success is a structured governance model and a detailed project plan with specific assignments and deadlines.

3. **Make physician engagement a priority.** Physicians will need to have a deep understanding of how the codes will affect their clinical documentation. While they may not be doing the coding themselves, they are going to have to be much more detailed in their clinical documentation.

4. **Avoid ICD-10 budgeting pitfalls.** Your budget needs to factor in the following: training needs, IT upgrades, system remediation costs, consulting needs, coding audits and clinical documentation audits.

5. **Project management is critical to a successful conversion.** Areas affected by this change include patient access, revenue cycle, physician documentation and patient care. You need a project manager to coordinate all of the activity.

---

Jim Riley, president and CEO, Capario

**Three ways to keep your bottom line in check**

As the ever-looming ICD-10 deadline continues to draw near, providers should have an ICD-10-capable billing system in place and be versed in how to successfully operate the system. While many providers have been focused on simply getting up and running, there’s a constant underlining concern around how ICD-10 is going to affect the revenue cycle.

ICD-10 is certainly not going to cause the next apocalypse, but providers should be aware that there may be some close calls when it comes to having excess funds during the first few months after compliance. There may be delays – even significant ones – to reimbursement, so it’s important to have access to additional dollars in case providers need to offset any temporary interruption in cash flow.

That being said, here are three other ways providers can keep an eye on their bottom line to ensure numbers are in check as ICD-10 compliance approaches:

1. **Test, test and test.** Don’t let the first time your practice puts ICD-10 to use be after the compliance deadline. Providers must work with their billing system, clearinghouse and payers to test common procedures and diagnosis combinations for their practice, starting six months prior to go-live.

2. **Use analytics tools.** After the go-live of ICD-10, access to tools that provide reimbursement trend alerts – categorized by payer, provider and biller – enables providers to pinpoint bottlenecks in the claims cycle and other concerns. This level of insight will be critical in eliminating negative patterns and maintaining steady reimbursement.

3. **Meet internally every day.** Meet with the team – anyone that touches claims processing, ICD-10 coding, etc. – to identify issues so that they can be addressed quickly. While particularly important
to meet on a daily basis once ICD-10 compliance starts, it’s also a good idea to meet periodically leading up to the transition to iron out issues along the way.

While ICD-10 will affect everyone differently, reimbursement doesn’t have to be a concern. Testing, analyzing and planning as an organization can remove much of the headache from the process and help organizations rest assured their bottom line is secure transitioning to ICD-10.

Michael Najera, VP, professional services, Craneware

**Best practices for clean claims**

All hospital claims contain charge data. Charge data is stored in the organization’s chargemaster. With increased focus on hospital pricing and charging, and the Department of Health and Human Services (HHS) open data initiative’s release of hospital chargemaster data to the public, best practices to ensure charge data accuracy and transparency throughout the organization are critical.

Clinical leaders may not be as familiar with the revenue cycle and changing payer requirements. Without a reliable process to validate that charge capture is complete and charge data is correct, missed charges and coding issues present significant risk and can cost hundreds of thousands of dollars. Chargemaster management is essential to mitigating revenue leakage, audit and compliance issues. Best practices for chargemaster accuracy include:

- Compare chargemaster data against Centers for Medicare & Medicaid Services (CMS) rules.
- Develop a team to verify charge data, including representation from all departments that create the medical record and that capture and account for services provided.
- Review with this team the charge data to ensure it is current, while identifying issues and barriers to charge capture improvement.

Support this team with tools enabling:

- A system-wide view of chargemaster data across business and clinical stakeholders with department-specific views.
- Automated workflow to assign, track and measure accountability.
- Easy access to information that answers questions on payer requirements.
- Prioritization of ongoing issues that are roadblocks to achieving optimal financial performance.
- The use of chargemaster data and the team’s findings to educate staff throughout the organization about the requirements for effective documentation.

With data in hand, leaders can identify and prioritize ongoing issues that are roadblocks to achieving optimal financial performance.
Critical steps to catching up

For provider organizations behind in the transition or not yet started, ICD-10 could be a nightmare. According to a recent report, 33 percent of providers haven’t started, and 22 percent don’t know where to begin. CMA and AHIMA have provided some resources, but with 12 months remaining, the time to act is now.

ICD-10 dramatically increases the number of codes, changes coding scheme structure and introduces clinical concepts, terminology and granularity, impacting every aspect of healthcare business. Some provider organizations hope for a deadline extension, while others don’t have enough resources to manage the transition.

Analyzing mountains of historical data to understand the ideal mapping between code sets can be complex due to a lack of a one-to-one relationship. However, organizations can mitigate this issue by identifying and prioritizing high-risk codes based on frequency of use, complexity of the mapping relationship and financial impact.

Next, provider organizations should work proactively with health plans to develop collaborative testing scenarios and assess results to compare reimbursements, identify discrepancies and adjust code maps to decrease the potential for revenue cycle and claim management disruptions. Providers shouldn’t wait for payers to contact them; providers who raise their hands can play a larger role in payers’ testing efforts, thereby decreasing post-transition surprises.

While the move to ICD-10 can seem daunting, those who haven’t started preparation need to prioritize the project. The deadline of Oct. 1, 2014, is quickly approaching, and a well-planned and tested transition strategy is a mission-critical endeavor.

Neutrality analytics key to successful transition

With October 2014 fast approaching, healthcare organizations are changing gears and going at double the speed to achieve ICD-10 compliance. Every healthcare IT organization is going through the traditional route of impact analysis, design, development and testing. Some are taking the crosswalk management route, while others are transforming their systems.
While these IT-focused steps may help achieve compliance, there is a key element of analytics that will ensure appropriate change management is performed at the business level. A new type of analytic solution, based on “neutrality” analytics, has emerged as an important part of the ICD-10 adoption strategy. Neutrality has four key dimensions: claims payment neutrality, member benefit neutrality, clinical neutrality and operational neutrality.

- Claims payment neutrality means the claims payment should remain approximately the same irrespective of ICD-9 or ICD-10 codes for a given diagnosis and medical procedure. It will ensure the payers do not end up paying too much (resulting in revenue loss) or too little (resulting in litigation and/or dissatisfied providers/members).
- Member benefit neutrality helps assess whether the member coverage remains the same post-October 2014, with no impact to premiums and out-of-pocket expenses.
- Clinical neutrality is about maintaining the same characteristics for patient care and meeting the same medical necessity outcome.
- Operational neutrality minimizes any deviations in operational parameters, such as claims adjudication throughput, first-pass ratio, call volume, etc.

Organizations that have factored in all four neutrality dimensions prior to an IT implementation should sail through the ICD-10 transition smoothly. Assessment of the above parameters might lead organizations to launch changes on the business side, such as renegotiating certain provider contracts, etc. Organizations bypassing this assessment/analysis could face turbulent times with a downward spiraling chain of events, including increases in claims rejection, manual prior authorizations, help-desk call volume, manual claim re-adjudication percentage and adjudication errors, as well as delayed payments to providers, incorrect payments and dissatisfied providers and members – not to mention management’s time and the organization’s reputation. With so much on the line, factoring in neutrality analytics in an overall ICD-10 strategy is extremely critical to deriving business value from ICD-10 compliance and providing greater assurance to stakeholders.

Andrea Clark, chairman and CEO, Healthcare Revenue Assurance Holdings (HRAA)

Many organizations haven’t begun preparations

A recent survey of hospital health information professionals and compliance employees conducted by HRAA found one in five small- and mid-size hospitals have not begun training for the enormous transition from ICD-9 to ICD-10.

Respondents stated:
- Forty percent have not begun ICD-10 CM training, and 55 percent have not begun ICD-10-PCS training for coding staff.
- Forty-seven percent have not begun document improvement education for medical staff.
- Thirty-one percent do not plan to dual code accounts prior to Oct. 1, 2014.
The majority of respondents do not plan to begin to dual code until 2014, despite CMS recommendations. Although respondents indicated hospitals are delayed in training and testing, 68 percent will submit ICD-10 coded claims to payers for testing prior to the transition.

Hospitals engaging in regular updates from patient account system (PAS) vendors regarding when their central repository for ICD-9 and ICD-10 data can be housed is critical for a variety of initiatives prior to the 2014 start date:

- Hospitals must have ICD-10 data for internal and external testing. End-to-end testing will replicate organizations’ systems to assess operational readiness and will flag unexpected outcomes prior to implementation.
- Perform dual coding efforts that are essential for inter-coder reliability – practicum equates to consistency, integrity and benchmarking of data.
- Building an arsenal of ICD-10 data achieved from dual coding or translation processes will assist the continued progress to mitigate financial risks for all payers. Denials must be anticipated as commercial payers will likely not recognize all of the ICD-10 codes when building their plans. Working with payers will eliminate any revenue suspension.

Amy Larsson, associate VP, emerging solutions, McKesson Health Solutions

**A stepwise approach to preventing waste and abuse**

Waste, abuse and fraud cost the healthcare industry an estimated $234 billion a year. With healthcare reform mandating drastic cost reductions, the need to stem financial losses from these areas has intensified, along with the need for better transparency and collaboration among payers and providers.

The implementation of ICD-10 represents another major disruption, as the change allows for interpretation during the claims coding process, inviting abuse. Complex payment models will make it harder to process claims correctly or understand whether services are necessary or being duplicated, creating waste. Further, most plans currently process payment claims separately from the systems in which they manage provider connections and utilization and investigate fraud and abuse. Each is operating off independent, disparate data and viewing various facets of the same problem, without seeing the big picture.

By broadening prevention efforts to tackle waste and abuse – not just fraud loss retention – and thinking of it in a phased approach that leverages comprehensive, real-time analytics and creates a dataset that enables payers and providers to work together, the larger need to increase collaboration and address systemic problems to deliver better, less costly care can be solved:

1. **Discover.** Find areas of claim- or provider-level aberrance that you wouldn’t otherwise know about without labor-intensive paid claims auditing or pure serendipity.
2. **Triage.** Quickly analyze findings of aberrance to identify potential level of waste or abuse and address it within the right areas of your plan.
3. **Optimize.** Address patterns of waste or abuse not only through provider education, but also by fixing issues within your systems, contracts or policies.

Waste, abuse and fraud may represent one more challenge confronting the industry today, but what if health plans could catch major coding and billing discrepancies in real time and address them before they become bigger, more costly problems for both the payer and provider? What financial and clinical impact could it have if we were able to direct those billions of lost dollars toward patients and better care delivery?

---

Michele Hibbert-Iacobacci, CMCO, CCS-P, VP, information management and support, Mitchell International

**A plan of action is imperative**

The Oct. 1, 2014, ICD-10 “doomsday” deadline is looming, and many healthcare providers fear they won’t meet the target date of completion. However, there is light at the end of the tunnel. As long as providers are taking the appropriate steps to prepare themselves for the implementation of the new codes, as well as software developments in the healthcare technology industry, they can expedite the process and eliminate pain points.

The key to successful implementation is, by far, creating a program that utilizes code sets around the project to be implemented. The biggest obstacle for ICD-10 implementation is time and financial resources, so it’s imperative that providers set internal expectations and align appropriate resources to handle the big switch. Providers can begin by preparing for the following: delayed payments, office frustration, temporary productivity handicaps, gaps in bill review systems and continual use of ICD-9 codes from HIPAA-exempt institutions.

As long as internal expectations are set, providers can proactively eliminate risk by staffing their team with the most skilled and knowledgeable professionals, allocating sufficient financial resources and re-evaluating vendor relationships. It’s also important that external expectations are set in order to facilitate internal transitions. Ask any vendor that integrates with your system and supports ICD-9 code what they’re doing to connect various streams to create seamless transition during this mandatory process. No plan will be fool proof, but if providers have a plan of action they’re already 10 steps ahead of the game.
Ana Croxton, VP, EDI products and services, NextGen Healthcare

**Five key questions to ask technology partners**

As the ICD-10 implementation deadline looms, healthcare organizations are continuing to struggle with preparation efforts. In fact, recent research from the Medical Group Management Association revealed that more than half of responding physician practices have not started work on the ICD-10 transition. According to the survey, one of the primary reasons for this delay is a lack of communication and coordination between physician practices and their technology partners, including EHR and practice management vendors.

While some vendors are proactive in contacting their clients, healthcare providers should not sit around waiting for the call. The time to reach out to your vendor about ICD-10 is now. Here are five questions to jump-start conversation.

1. **Where do I direct ICD-10 questions?** Most vendors have dedicated staff available to address both administrative and clinical questions related to the new code set. Knowing who to contact with questions and establishing a relationship with that individual or department can get questions answered faster and more accurately.

2. **What is the upgrade schedule?** If you don’t already know, you should be asking all your technology partners when their updated software will be available and how much it will cost. In some cases, the upgrade may be part of your vendor contract, but in others it will require an additional fee.

3. **Do we need to upgrade our hardware to support the new software?** ICD-10 requires a fairly extensive upgrade to most vendors’ software. If your organization is using antiquated hardware, you may have to upgrade to support the new release.

4. **What happens on Oct. 1, 2014?** Asking your vendors how they will communicate with you as the code set goes into effect and how they will help you navigate changes and unexpected issues can demonstrate what kind of partnership you expect from your vendors as legislation continues to evolve.

5. **What training resources does the vendor have?** Your vendors may offer webinars, downloadable resources and training tools to help clients prepare for ICD-10. Find out what resources are available and leverage those to ensure both your clinical and administrative staffs are prepared for the transition.

Mark Morsch, MS, VP, technology, Optum

**Natural language-processing technology critical to success**

Many hospitals are considering computer-assisted coding (CAC) technology to assist their ICD-10 readiness efforts and address other billing and compliance challenges.
To maximize return on these investments now and into the future, it is critical to understand how varying methodologies behind the natural language-processing (NLP) technology powering CAC affect its performance.

The NLP engine is responsible for reading clinical documentation to identify diagnoses and procedures and then recommending the codes assigned to clinical cases. Five distinct methodologies drive the ability of NLP engines to organize and extract meaning from clinical documentation. In simple terms:

- **Medical dictionary matching** maps words in the clinical documentation to medical terminology.
- **Pattern matching** finds word patterns that describe a diagnosis or procedure.
- **Statistical** uses pre-coded documents to train and evolve algorithms.
- **Symbolic rules** identify codes from language using linguistic rules and symbols.
- **Symbolic rules and statistical components** – a more advanced approach – uses a hybrid of mathematical modeling and linguistic rules to identify meaning and context.

Of the five NLP methodologies, the symbolic rules and statistical components approach is best suited to the scale and rigors of ICD-10. It is uniquely capable of interpreting words and phrases in their medical context, determining whether they are relevant to current or past diagnoses or the patient's family history, and coding granular details, ranging from laterality to severity and acuity, that are critical to timely, accurate payment.

CAC technology will be addressing ICD-10 and other business challenges facing hospitals. Getting familiar with what’s under the hood of CAC applications is essential to achieving optimal performance for medical coding and beyond.