IMPROVING YOUR ICD-10 PROGRAM
Preparing for October 1st 2016 & Beyond

written by
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Introduction

The challenge has just begun. The US healthcare industry’s transition from the 9th Version of the International Statistical Classification of Disease (ICD-9) to the 10th version (ICD-10) has been the most significant change to be initiated across the industry in decades, but the go-live was just the beginning. Just like any technology implementation, the post-go-live initiatives are just as, if not more, important than the actual implementation. Submitting claims, having claims denied or reimbursed, using the correct codes to prepare for a looming medical record audit—these are all the things that keep an organization afloat, operationally and financially.

Originally mandated in 2008, the political sphere has been delaying, and delaying, and delaying the deadline for providers to switch to ICD-10. To the industry’s surprise, last October (Oct. 1, 2015) marked the end of delaying and the beginning of ICD-10. While some organizations felt prepared, a strong majority of healthcare providers were banking on another delay, or were once ready, but because of continuous delays, had to start training and preparedness efforts from scratch.

The coding complexity of the switch from ICD-9 to ICD-10 includes the addition of deeper levels of specificity within the coding sequence, as well as the introduction of alphanumeric codes, compared to the strictly numeric ICD-9 codes—in summation, the number of diagnostic codes jumped from 13,000 to 68,000 possible codes to classify a patient’s medical condition. Concurrently, the codes for procedural coding were updated as well, increasing from 3,800 to 72,000 procedure classification codes.¹

So what is being added to the classification system to account for such dramatic increase in coding volume? Specificity, that’s what. The latter codes in a sequence now allow for doctors to include precise location on a patient’s body part or internal organ, what kind of circumstances caused the disease, or if there were any complications before, during, or after a procedure. The introduction of the level of granularity available in documentation will directly impact the improvement of care, population health surveillance, and allow for pay-for-performance payment models to flourish.

Due to the sheer magnitude of the transition, but the necessity of pressing forward, the October 2015 deadline went into full effect, but with leniency for the first 12 months of ICD-10—a much welcomed “grace period,” granted by Centers for Medicare & Medicaid Services (CMS). Now that the go-live has happened, the initial dust has settled, and providers have until Oct. 1, 2016 before penalization begins, the time is now to strategize for the future, plan for hiccups and successes, and improve coding to achieve higher reimbursement and lower denials.

Ensuring Success before Oct. 1, 2016

In January, February, or even March of 2015, most providers, industry stakeholders, and political figures expected yet another ICD-10 delay to make it into legislation before July, 2015. Waiting and waiting for the delay that would never come, many provider organizations put off full-fledged ICD-10 initiatives, while others prepared as stringently as they had for the initial deadline of Oct. 1, 2013. Whatever category an organization falls under, the deadline is the same for everyone, and the industry as a whole is adjusting to the most dramatic change in healthcare in decades. To ease the transition for all providers, CMS ruled that:
“While diagnosis coding to the correct level of specificity is the goal for all claims, for 12 months after ICD-10 implementation, Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule...However, a valid ICD-10 code will be required on all claims.”

This grace period comes as a great relief to providers feeling underprepared and those providers feeling exceptionally prepared—no matter how much you can prepare, any change of this magnitude comes with glitches, training lapses, and a risk for revenue losses.

In the coming months leading up to Oct. 1, 2016, providers will be diligently and tirelessly working to improve ICD-10 coding to reduce denial rates, increase reimbursement rates, and get revenue back to normal. Most providers are expecting a significant loss in initial cash flow related solely to coder and physician productivity losses because of clinical documentation and specificity required in ICD-10. Impacts on people, process, and technology will also be vast—initial decreases in cash and reimbursement, increased DNFB and A/R Days, and increased payment error rates are some examples of where the impact will be significant. The following areas in the revenue cycle will be impacted the most as a result of the ICD-10 go-live:

- Scheduling/Registration
- Pricing
- Clinical Intervention
- HIM
- Charge Capture Entry
- Claims Processing
- Clinical Documentation
- Case Management
- Coding Assignment
- Account Resolution
- HIS/CPOE
- Claims Clearinghouse

With such a dramatic impact on a facility’s entire business and clinical operations, provider organizations must continually reevaluate their ICD-10 programs in place and implement course corrections when necessary to ensure physician clinical documentation compliance, coding accuracy, and minimal patient impact. To ensure operations, physician relationships, and revenue are minimally impacted during the months leading up to and after Oct. 1, 2016—there are four (4) essential projects to initiate within the Financial and Clinical Departments: Ongoing ICD-10 Training Programs, Clinical Documentation Improvement Programs, Regular Coding Audits (Internal & External), and RCM Metrics Reporting. In the following sections, we will cover what frameworks to use when building the programs, expected resource needs, and the benefits of the programs to provider organizations over the next year.

**Ongoing ICD-10 Training Programs**

Preparing your team for the transition from ICD-9 to ICD-10 was critical before the ICD-10 go-live, but maintaining that training across your coding team is just as important to ensure quality reporting, reimbursement, and coding accuracy. While the jump from 13,000 to 68,000 code possibilities is significant, your team does not necessarily need to be trained on all 68,000 codes, but rather trained in the top 100-200 codes most used at your organization, along with the various levels of specificity available in the new ICD-10 code sets. Providers are faced with a three-pronged challenge in finding qualified ICD-10 coders:

1. ICD-9 Coders trained for ICD-10 lack experience and certifications
2. Certified ICD-10 Coders lack hands-on experience
3. ICD-10 Coders with hands-on experience are elusive and expensive
It’s important to remember that the transition from ICD-9 to ICD-10 is not an upgrade. ICD-10 represents a major shift in the structure and logic of the coding classification system, and requires significant effort by the coding, and other staff teams, to re-educate and relearn coding concepts and rules. Ongoing, effective training and education programs pre and post ICD-10 go-live can combat any experience lapses or capability insecurities your team may experience after going live with the new and more granular coding requirements. Training in fundamental clinical topics, such as anatomy and physiology, medical terminology, clinical pharmacology, and other biomedical science areas, may also be an important area to consider when deploying training programs. Some important elements to include in your ongoing training program are:

**Develop and continually update quick-reference guides with ICD-9/10 coding fundamentals**

- E.g. Code Crosswalking/Mapping Guide to the top 50 diagnostic codes

**Recognize and deploy the most appropriate training delivery methods:**

- Workshops
- Lunch & Learns
- Online, Pre-Recorded Seminars
- Self-Study Tools

**Develop education tools and resource database, with:**

- Case Studies
- User Manuals
- Technical Guides
- Video Tutorials

**Identify any need for more advanced coding education in complex specialty areas**

While your Ongoing ICD-10 Training Program should be focused mostly on training your coders (HIS, HIM, and CPOE), it’s also important to foster a culture of physician/coder partnerships to encourage improved physician documentation. This leads us to the essential program every provider organization should be implementing over the next year: The Clinical Documentation Improvement Program.

**Clinical Documentation Improvement (CDI) Programs**

Improving clinical documentation across your organization after the ICD-10 transition will not only have a significant impact in understanding the quality of your organization’s clinical documentation, but will also facilitate better representation of your organization’s services via accurate reporting of diagnoses and procedures. Successfully doing this with the deployment of a CDI Program can improve quality measures, admissions, value-based purchasing, and clinical decision making, while reducing compliance and audit risks. Investing resources to develop a comprehensive CDI Program is worth the financial and human impact for both quality and revenue improvement.
To better understand where to begin your CDI initiative, start by conducting a current state assessment to look at current ICD-10 coding patterns, and then put together an internal committee with stakeholders from the Clinical, Business, Compliance, and HIM Departments to determine future goals to achieve with a CDI Program. Establishing a committee/program charter, as well as CDI policies and procedures, will foster accountability, enterprise-wide education, and Departmental buy-in.

Encouraging interview exercises with Department Heads is a good practice to instill—this will ensure your committee has a “big picture” perspective of clinical documentation goals from across the organization, and will aid in establishing involvement from essential teams and departments, especially physicians. Appointing a Physician Liaison, either internally or as a new hire/advisor, is a key position when beginning a CDI program. This resource acts as a champion for the program and can foster better, more transparent communication between Clinical and HIM Departments.

Policies and procedures put into place as a result of the current state assessment, committee development, and overall program inception will act as guides for hiring CDI professionals, onboarding and training, standardized query practices, and define quality assurance. A CDI professional can come in different forms, varying from experienced coders to former physicians—the key ingredient is deep knowledge in coding and/or a clinical background, while expertise in both backgrounds is ideal. Competencies of CDI professional include:

- Coding Fundaments & Guidelines
- Medical Terminology & Clinical Knowledge
- Familiarity with Patient Records/EHRs
- Knowledge of Healthcare Regulations

Clinical Documentation Improvement professionals work with physicians, either one-on-one or during shadowing exercises, to assist with and help gather provider documentation when updating electronic patient records. Often times, the Physician Liaison will facilitate these interactions initially to ensure ease of transition for the provider. Different from traditional settings, information can be gathered by a CDI professional through the query process (previously HIM responsibility). A query, or the gathering of missing or inaccurate information in a medical record, is an important aspect of improving clinical documentation, as it acts as a performance evaluation tool for physicians, advocating for complete,

**Leading Query**: Please document if you agree the patient has chronic diastolic heart failure.

**Nonleading Query**: It is noted in the impression of the H&P that the patient has chronic congestive heart failure and a recent echocardiogram noted under the cardiac review of systems reveals an EF of 25%. Can the chronic heart failure be further specified as:

- Chronic Systolic Heart Failure
- Chronic Diastolic Heart Failure
- Chronic Systolic and Diastolic Heart Failure
- Some other type of Heart Failure

*Figure 1, Clinical Documentation Query Example*³
quality documentation. Creating customized template queries for CDI personnel is a useful tool in expediting the process, as well as ensuring queries do not probe or lead physicians into choosing one diagnostic code over another.

With the implementation of ICD-10, this practice is even more necessary than ever before, as the level of specificity available to providers now—who will need to adjust to documenting additional details—is not only new, but vast and essential to improved quality measures and other revenue benefits over the next several years.

**Regular Coding Audits (Internal & External)**

Whether a CDI Program is in place or not, internal chart audits/medical record review can offer your organization valuable insight into medical record quality and accuracy as your physicians and coders submit more claims using ICD-10 code sets. While the CMS has granted coding leniency, organizations should still be making an effort to code as accurately and completely in ICD-10 as possible in anticipation of Oct. 1, 2016 when the CMS grace period is lifted.

The key to conducting successful audits internally is to pull records from all departments, at random, without any preparation for your team—simulating a “real” audit is an exceptionally important practice, as there is no forewarning for an external government audit conducted by Zone Program Integrity Contractors (ZPIC), Recovery Audit Contractor (RAC), or Medicare Administrative Contractor (MAC).

What can be expected from a medical record audit? A total review of all facets of a clinically documented medical record, including adequacy and completeness of physician or other clinical documentation in support of clinical validation of diagnosis. Other factors such as whether the completeness of the documentation captures clinical judgement, and if the thought processes leading to a diagnosis are clearly represented. Related to coding, the validation of coding accuracy based on utilization of available clinical documentation, including accuracy of principal diagnosis, Comorbid Condition (CC)/Major Complicating Comorbid (MCC) and Medicare Severity (MS)/All Patient Refined (APR) Diagnosis Related Groups (DRG) assignment and adherence to official coding guidelines.

A measurable tool in tracking your own organization’s compliance percentages post-audit is to maintain the information in a database and compare improvement rates and with other programs in place, i.e. ongoing ICD-10 coding training and CDI programs. Program cross-over can also be valuable when utilizing, coders and CDI professionals as important assets when conducting internal audits.

While conducting regular internal audits is a proven way to monitor and maintain the quality of medical records and coding assignment, it’s also valuable to bring in third party auditors to do a review of several hundred records per month over a two-three months duration to manage a larger volume of medical record audits without disrupting your organization’s day-to-day business operations. Performing large-scale, comprehensive audits can require a team of three-four auditors and CDI professionals, a time and resource burden many organizations will not be able to spare, especially with a focus on improving coding and clinical documentation practices simultaneously.
RCM Metrics Reporting

With last year’s ICD-10 conversion in full swing, healthcare providers are continually challenged with maintaining expected reimbursement rates and claims denials. The mandate to improve productivity while simultaneously controlling costs and maintaining expected cost-to-collect ratios is creating a significant burden for many organizations. Deploying an RCM analytics strategy or solution can monitor RCM metrics, and help an organization understand, correct, and improve their reimbursements.

In any RCM or HIM environment, it is extremely important to monitor all aspects of the financial and operational direction by deploying organizational and industry benchmarks to compare and maintain expected reimbursement outcomes. However, with the implementation of ICD-10 and more complex coding requirements, quality requirements, and coding accuracy, simply monitoring benchmarks may not be enough to stay competitive.

Reimbursement analytics and defined metrics provide the tools and insights that can help drive more strategic decisions and improve the overall financial health of an organization. With the potential near real-time access to actionable reimbursement and productivity metrics, RCM and HIM leaders can deploy and react to necessary changes, disruptions in the flow of reimbursement, and identify any abnormalities that are effecting operations and expected reimbursement levels.

Identifying key performance indicators (KPI) metrics, such as AR Days, DNFB, CMI, and Denial rates, as well as workflow, coding effectiveness, benchmark comparisons, billing, and collection trends, can help optimize profitability while improving processes. Reimbursement analytics and metrics enables the organization to streamline processes for improved staff efficiencies and faster reimbursement, so that RCM and HIM leaders can quickly identify and respond to changes in an increasingly competitive market. This part of your ICD-10 improving initiatives is an advanced improvement approach, and often requires a reliable third party software vendor and management team to not only begin the initiative, but also ensure continued metrics monitoring.

Conclusion

As the industry passes over the interchange of ICD-9 to ICD-10, there will be opportunities for organizations to squander in the change, or flourish to achieve improved patient satisfaction, clinical quality, and reduced operational costs. The investments, in both monetary and human capital, necessary to initiate the programs discussed in this paper will return that investment tenfold if executed successfully. A common reaction to ICD-10 is that the initial cost of implementation and associated resource costs do not outweigh the initial benefits of the code set, but that a ROI is expected in the long term. That ROI will only come if organizations are actively optimizing their coding, documentation, and auditing practices, as well as deploying RCM metrics reporting. ICD-10 opens up the opportunity to achieve improved patient satisfaction and build a use case for value-based-purchasing to align with the industry's Triple Aim goal of improved delivery of care, managed population health, and lower operational costs and costs to the patient.
References


About the Authors

Bill Ayres. As Divurgent’s Vice President of Revenue Cycle Management, Bill works alongside Divurgent’s Leadership Team and his own tenured Team of healthcare professionals to create innovative solutions to the most critical areas of healthcare revenue cycle. Preparing organizations for the implications of today’s changing healthcare environment, Bill provides services for ICD-10 transition efforts and best practices, revenue cycle process improvement, and revenue cycle and clinical application alignment.

Bill is an experienced healthcare executive with over 22 years of expertise in healthcare revenue cycle management, accounts receivable (A/R) management, cash acceleration, as well as healthcare delivery with both Payer and Provider markets. Before Divurgent, Bill worked with a variety of healthcare organizations and areas, including healthcare providers, healthcare payors and managed care organizations, medical imaging firms, and financial service organizations.

Masters of Business Administration (MBA) graduate of Pepperdine University, Bill also has a Bachelors of Arts Degree from Central Michigan University. Additionally, Bill serves as a senior member of the Los Angeles Chapter of the Healthcare Finance Management Association (HFMA) and sits on the CFO committee.

Company Overview

Divurgent is not the typical healthcare consulting firm. As a nationally recognized company, we are committed to healthcare evolution and the strategies and processes that make it possible. We help our clients evolve in payment and delivery reform, as well as patient engagement, providing higher quality of care, lower cost of care, and healthier communities.

Focused on the business of hospitals, health systems and affiliated providers, Divurgent believes successful outcomes are derived from powerful partnerships. Recognizing the unique culture that every organization offers, we leverage the depth of our experienced consulting team to create customized solutions that best meet our client’s goals. Utilizing best practices and methodologies, we help improve our client’s operational effectiveness, financial performance, and quality of patient care. For more information about Divurgent, visit us at www.divurgent.com
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